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ABSTRACT

Volume of 4 and 5 contain lessons that provide expert information on a variety of ethical issues in professional counseling. The lessons included in these volumes may be applied toward continuing education credits. Lessons in volume 4 are: (1) "Ethics in Substance Abuse Rehabilitation" (Robert L. Hewes); (2) "Ethical Dilemmas in Multicultural Counseling" (Paul B. Pedersen); and (3) "Ethics: Philosophical Roots--Practical Implications" (Rita Sommers-Flanagan). Lessons in volume 5 are: (1) "Ethics in Family Therapy" (Jill M. Thorngren and Adina J. Smith); (2) "Ethical and Legal Dimensions of Counseling in Schools" (Darrell W. Stolle); and (3) "Managed Care as an Ethical Issue (Scott T. Meier and Susan R. Davis). Each lesson contains references. (GCP)

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ED 464 293

# Ethical Issues in Professional Counseling
# Volume 4 [and] Volume 5

2001

Frederic Flach, Editor

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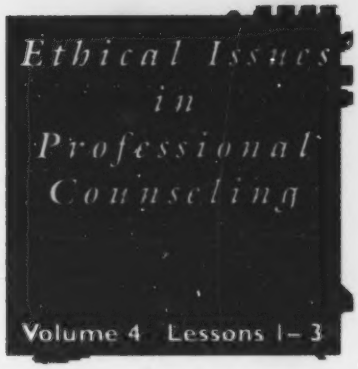


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**CET-04**

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# Ethics in Substance Abuse Rehabilitation

Robert L. Hewes, RhD, CRC

*Dr. Hewes is an Assistant Professor of Rehabilitation and Disability Studies, and Coordinator of the Alcohol and Substance Abuse Counseling Graduate Program at Springfield College, Springfield, MA.*

## Introduction

The abuse of alcohol and other drugs continues to be an overwhelming societal problem affecting the lives of millions. Evidence of this fact can be seen in the numerous alcohol- and other drug-related fatalities, accidents, and domestic disputes reported in the United States each year. In 1995, the total estimated cost of alcohol abuse and dependency in the United States alone was $150 billion.[1] Additional personal costs—such as emotional and psychological problems, loss of life due to suicide and violence, as well as disruption and trauma in the home—continue to strain and impose complexities on the role of the substance abuse rehabilitation professional.[2]

More specifically, within this complex environment, substance abuse counselors must learn to make difficult case management decisions regarding their client's well-being. Many rehabilitation professionals make such decisions when taking into account specific client-related information (e.g., physical, emotional, social, economical, family support, and coping skills). Ultimately, these decisions are ethical. Practitioners are often influenced by their own personal values, beliefs, and attitudes; the values held by their clients; the values of their professional organization or agency; and the general values held by society. This lesson provides a focused discussion aimed at helping the reader recognize and resolve ethical dilemmas, as well as a step-by-step process designed to facilitate ethical decision making in rehabilitation counseling practice. After completing this lesson, the practitioner should be able to:

- **Recognize the contextual forces that influence ethical practice by substance abuse professionals.**
- **Explain the roles that personal values, client values, and organizational values play in ethical decision making.**
- **Interpret the Code of Ethics for Rehabilitation Counselors as an important standard for guiding professional behavior.**

- **Understand basic principles of ethical conduct.**
- **Define an ethical dilemma.**
- **Put an ethical decision-making model into practice.**

## The Changing Practitioner

**The field of substance abuse counseling is especially heterogeneous with respect to gender, culture, race, age, sexual orientation, education, and training.** As a result, diverse and often conflicting views have impacted professional practice and further complicated already complex ethical issues.[3] The field of substance abuse counseling has a fairly recent inception and professional identity. **Only in the past few decades has a significant portion of substance abuse counselors received advanced graduate degrees and credentials.**[4] Prior to this surge in advanced education, many substance abuse counselors were persons in recovery. In short, the emphasis on advanced degrees has led to a high turnover rate in the profession, resulting in less experienced practitioners. **Additionally, many of these practitioners have limited training in ethics and are often hard pressed to resolve or even recognize ethical dilemmas in practice.** The responsibility for ethical practice does not fall completely on the practitioner, however. In general, the field does not have an absolute ethical framework within which it works consistently.[3] **In the past, ethical dilemmas in the substance abuse counseling field were resolved when the professional codes of practice of other fields, such as psychology or medicine, were considered.** Given the current state of the field and the diversity of its practitioners, this approach appears to be quite limited.

It is also important to realize that counselors perceive ethical dilemmas in the workplace as increasing. **As a result, they often feel overwhelmed early in their careers due to their lack of preparation in ethics, specifically the process of ethical decision making.**[3] **Part of the problem is that practitioners often feel that ethics is a personal issue separate from organizational structure or boundaries. In fact, ethics should be viewed as a personal, professional, and organizational issue.** Organizations in this field have made attempts to support the practitioner's sense of morality and professional behavior through laws, legislation, and the interpretation of societal attitudes without offering much substantive assistance to prepare the individual to recognize the problems and issues in practice.[3] **In addition, because these practitioners come from a variety of training backgrounds** (e.g., social work, rehabilitation counseling, and psychology) **with limited exposure to ethics education, the task of increasing counselor competence in this area is critically important.** One of the first concepts a new practitioner must understand is that of the contextual forces that influence ethical behavior. These forces are often reflected in societal attitudes and organizational policy.

## Societal Values That Affect Service Delivery

**Ethical behavior is often influenced by the perception of approval by others. That is, an action may appear to be ethical to a novice practitioner if she or he can be assured of majority support.** This sort of chain reaction can be seen in the influence of societal attitudes on substance abuse treatment in the United States.

**Societal attitudes and responses toward persons with disabilities are often determined by the perceived responsibility for the disability.**[5] **For example, a person who is believed to have caused her or his own disability by a voluntary action** (e.g., illicit drug use, driving while intoxicated, or promiscuous sexual activity) **will often receive less compassion than a person who is born with a disability and therefore not responsible for it.** Alcohol dependency is widely considered by society to be a "self-inflicted disadvantage" based more on a lack of willpower than an uncontrollable genetic or environmental force. A society with such a perspective will likely treat persons defined as alcohol dependent adversely[5] and show even less compassion.[6] **In fact, those who are perceived as being responsible for and succumbing to alcohol dependency are viewed less favorably than those perceived as being responsible for and coping with their condition.**[7] This sort of perception can have an impact on a novice practitioner, who may treat those clients who appear to be coping with their condition more favorably.

**Society's response to persons with disabilities is not influenced solely by perceptions of responsibility. The extent to which society perceives them as a threat will also dictate its response.**[5] For example, the ongoing "war on drugs" is the epitome of perceived threat to personal safety. This phrase, which is now part of the national vernacular, suggests that people who abuse alcohol and drugs are enemies of the American people; as such, they should ultimately be feared and avoided.[8] **Persons who are dependent on alcohol or other drugs also elicit feelings of fear and danger that are associated with economic security.** A clear example of this is seen in neighborhoods in which the fear of a reduction in property values develops with the establishment of local high-risk rehabilitation centers, such as drug treatment facilities.[5] The U.S. media often perpetuate these perceptions of fear through negative and stereotypical images.

**Bombarded with these images and an "us-vs.-them" philosophy, society naturally concludes that persons who abuse alcohol and drugs are not worthy of compassion or treatment.** Such conclusions ultimately place enormous pressure on treatment providers. For example, although alcohol dependency is defined as a disability by the Americans With Disabilities Act (ADA), it is difficult for a person with alcohol dependency to be entitled to the formal status of having a disability. To be covered, individuals with alcohol dependency must be abstinent from illegal drug use and currently or previously in treatment for alcoholism.[9] This condition of exclusivity denies the much needed entitlement status to those with comorbid alcoholism and drug abuse. Societal attitudes that directly influence public policy[10] directly prevent people with comorbid drug and alcohol abuse from gaining entrance to treatment facilities.

## A Shift in Treatment Planning

The field of addiction treatment has expanded greatly over the past 20 years and has even become a profitable industry. **Still, the traditional and well-established approach to substance abuse treatment is based predominantly on the disease model and the 12-step principles of Alcoholics Anonymous.**[11] These models have been adopted almost universally by substance abuse treatment facilities for use as a "one-size-fits-all" treatment approach.[12] Although Alcoholics Anonymous and the disease model of treatment are credited, at least anecdotally, with helping millions of people "recover," no empirical research findings support this claim.[13] Nevertheless, clients often have few alternative treatment methods to choose from.

Not surprisingly, there has been an enormous debate on the effectiveness of inpatient vs outpatient treatment programs and the influence of the length of stay (e.g., 14 vs. 28 days) and the intensity of a program. However, in a review of more than 600 studies, Miller and Hester[13] concluded that the content or focus of treatment is more important than the way in which it is provided (ie, its duration, setting [inpatient vs outpatient], or intensity). Furthermore, researchers have recognized that no one treatment approach is likely to be effective for every client.[13,14] As a result, the focus of the alcohol abuse and dependency treatment field has shifted from overall treatment outcomes to the impact of matching clients with appropriate treatment strategies.[14] This emerging model views alcoholism as a complex disorder that demands a complex treatment approach and effective case management decisions. At a time when managed care programs greatly influence treatment design, the organizational pressure to conform to professional wisdom creates numerous ethical problems for the practitioner who must operate on a one-on-one basis with the client.

### Realpolitik:

**Without a clear set of ethical standards for practice, counselors may feel pressured to conform or comply with a particular set of beliefs, causes, and treatment modalities for persons with alcoholism and drug addiction.[15] This professional environment, referred to as *Realpolitik*, may contradict a clearly defined set of standards.** In the substance abuse treatment field, Realpolitik is often characterized by the emotional intensity generated by controversial treatment approaches and beliefs which surround the etiology of alcohol addiction.[15] **Moreover, Realpolitik is demonstrated by the force exerted to preserve ideological conformity in treatment modality and etiology.** The professional resistance surrounding controversial treatment approaches, such as controlled drinking strategies, is well documented.[15-17] Counselors often feel

anxious and apprehensive when considering such treatment options due to the pressure to conform. Haskell[15] describes this phenomenon as an authoritarian group process that pressures professionals to conform to the disease concept of addiction. In addition, Miller suggests that ". . . there is immense sociopolitical pressure in the U.S. addictions treatment field to endorse an abstinence-only approach."[16] Ultimately, this influence may result in a decreased menu of treatment options available to the client.

Clearly articulated ethics and values can improve and guide professional conduct. **A clear set of standards and an ethical framework may help practitioners clarify case management decisions and increase the counselor's competence in serving the client.** Because professionals must deal with such pressures and make effective case management decisions, an ethical decision-making model is warranted.

## Broadening Our View of Ethics

Understanding ethics requires a broad view. One must look at the micro- as well as the macro-contextual forces. In short, ethics should be embraced as a systemic issue, one that transcends the counselor–client relationship to address societal and public policy implications, as well.[3,18] **Too often the counselor views ethics as an individual issue based on a personal morality.** In effect, the counselor ignores the contextual forces that influence his or her professional behavior and instead perceives ethical dilemmas as personal issues that are to be resolved on the basis of the individual practitioner's own sense of morality and personal ethics. Understanding the dilemma of subjective variety, many agencies and organizations have adopted codes of professional practice to help guide professional behavior in a complex environment.

### Code of Ethics:

The Commission on Rehabilitation Counselor Certification (CRCC) was developed in 1973, in part as a response to the consumer rights movements in the 1950s through the early 1970s. The CRCC first published the Professional Code of Ethics in 1987.[19] **The primary purpose of this code is threefold:** (1) **to protect the health and safety of the client by providing professionals with acceptable standards of quality in such areas as education, training, work experience, and knowledge of the field;** (2) **to provide guidance for professional behavior and practice by outlining canons and rules that specify proper conduct and behavior for the rehabilitation professional; and** (3) **to protect and promote the professional identity and integrity of the profession.** The 10 canons in the Code of Ethics cover moral and legal standards, counselor–client relationships, client advocacy, professional relationships, public statement/fees, confidentiality, assessment, research activities, competence, and CRC credentials. Each canon has several rules that delineate standards of professional conduct. Ultimately, each rule is supported by an ethical principle that is outlined in the following section.

### Ethical Principles:

**In order to recognize and ultimately resolve an ethical dilemma, a practitioner should be familiar with the ethical principles that serve as the foundation for the professional Code of Ethics. While ethical standards are not identical for all professions, most codes of professional ethics share basic principles.[20]** The following five ethical principles have been emphasized extensively in the fields of medical ethics,[21] psychology,[20] and rehabilitation counseling.[22,23]

#### *Autonomy*

***Autonomy* refers to independence, freedom and the capacity for self-governance.[20]** The focus of ethical conduct for rehabilitation counselors is to allow the client to have an autonomous voice in his or her treatment. **The counselor should allow the client to make decisions voluntarily and without coercion after all treatment information has been provided. A counselor adheres to the principle of autonomy by respecting a client's right to make choices based on personal values and beliefs. The counselor does not impose his or her will on the client, because "autonomous actions should not be subjected to controlling constraints of others."[21]** An example of autonomy is provided in R2.1 in the Professional Code of Ethics for Rehabilitation Counselors: "Rehabilitation counselors will make clear to the clients, the purposes, goals, and limitations that may affect the counseling relationship."

### *Beneficence*

**The ethical principle of beneficence emphasizes an obligation to promote the client's welfare** (i.e., the counselor acts for the benefit of others). **Beneficent actions involve the promotion of good and the removal of conditions that will cause harm to others.**[20] Acting in a beneficent manner is considered a professional obligation and should be the primary intent of rehabilitation counselors. The difficulty with beneficent action often concerns the maintenance of a balance between the degree of aid the counselor should provide and the degree of aid the client requests. **Overall, practitioners are charged to place their clients' interests above their own according to the following three conditions:** (1) **the special knowledge, training, and education of the counselor or rehabilitation professional;** (2) **the power and control the counselor has to provide or withhold benefits or resources; and** (3) **societal expectations that the profession will promote the overall well-being of its clients.**[21] An example of beneficence is provided by R3.5 in the Code of Ethics: "Rehabilitation counselors will remain aware of the actions taken by cooperating agencies on behalf of their clients and will act as advocates of clients to ensure effective service delivery."[20]

### *Nonmaleficence*

**The first rule of health care is "Do No Harm." Similarly, the principle of nonmaleficence requires the professional to act in manner that either causes no harm to a client or prevents a harmful situation.** Nonmaleficence may be achieved by refraining from or avoiding harmful actions or situations, as opposed to beneficence, which is more action-oriented in that it promotes well-being.[22] An example of nonmaleficence is provided by R4.7 in the Code of Ethics: "Rehabilitation counselors will function within the limits of their defined role, training, and technical competency and will accept only those positions for which they are professionally qualified."[19]

### *Justice*

**The principle of justice requires practitioners to treat clients fairly.** According to Beauchamp and Childress,[21] however, "scarcity and competition make [distributive] justice a troublesome ethical problem." The philosopher John Rawls describes justice in terms of fairness and fundamental rights;[21] most health care professionals, especially rehabilitation counselors, hold the principle of justice to be the fair allocation of monies, resources, and time.[24] **Six criteria are often applied in distributive justice decisions: equal shares** (e.g., each client would receive an equal portion of available resources); **need** (e.g., clients who take an active role in their treatment plan often receive continued services); **motivation and effort** (e.g., veterans are often afforded additional services due to their contribution to society); **contribution** (e.g., clients with an underserved disadvantage often receive additional benefits and services); **free-market exchange** (e.g., private sector rehabilitation); **and fair opportunity** (e.g., clients with an underserved disadvantage often receive additional benefits and services). An example of justice is provided in R5.1 of the Code of Ethics: "Rehabilitation counselors will consider carefully the value of their services and the ability of clients to meet the financial burden in establishing reasonable fees for professional services."[19]

### *Fidelity*

**Similar to beneficence, fidelity focuses on loyalty and honesty in professional relationships between the rehabilitation counselor and clients, colleagues, organizations, and agencies.** This ethical principle requires practitioners to faithfully keep all promises and commitments, both stated and implied, that they have made to others. Protecting client information and refraining from sharing or divulging private information about the client (i.e., confidentiality) are clear examples of the ethical principle of fidelity. Another definition of fidelity is provided by R6.9 in the Code of Ethics: "Rehabilitation counselors will provide employers with only job-relevant information about clients and will secure the permission of clients or their legal guardians for release of any information which might be considered confidential."[19]

Despite the establishment of ethical conduct standards, ethical dilemmas will be encountered by the professional. Often the rules of professional conduct will be the source of conflict. For example, a counselor may want to support the wish of a particular client to transfer from a local community college to a private college in order to enroll in a special program in hotel manage-

ment. Following the ethical principle of autonomy, the counselor should incorporate the client's desire into the treatment plan. However, the counselor's agency may not be able to take on the burden of the higher tuition charged by the private college. According to the principle of justice, the counselor must be fair in the distribution of resources to all clients. Thus, the client's request presents the counselor with an ethical dilemma.

## Increasing Counselor Competence

**It is often difficult for the less experienced counselor to recognize and define an ethical dilemma.** For example, a counselor who works with persons who are incarcerated may be offered a gift by an inmate or a client's family. Although it is clearly stated in the counselor's professional code of conduct that employees should not be the recipients of gifts, the counselor may be torn between accepting the gift or refusing it and thus, straining the counselor-client relationship. However, there should be no ethical dilemma: the code of conduct clearly indicates what action should be taken. Still, the gift offer places the counselor in an awkward position.

This example offers a working definition of an ethical dilemma. An ethical dilemma exists when two or more ethical principles or values come into conflict and suggest opposing courses of action. While each course of action can be supported by an ethical principle, one course of action compromises the ethical principles that support the course of action not chosen.[23] Again, this definition demands that counselors understand the foundation of a code of ethics (i.e., the ethical principles) so that they will be able to recognize and resolve ethical dilemmas.

**Once an ethical dilemma is recognized, the application of an ethical decision-making model to case management is beneficial; such a model can help the professional critically analyze a case and mitigate any pressure experienced by the counselor.** Millard and Rubin[25] offer the following six-step ethical decision-making model:

- **Review the case situation and determine the two courses of action from which one must choose.**
- **List the facts that support each course of action.**
- **Given the reasons for supporting each course of action, identify the ethical principles that support each action.**
- **List the fact-based reasons for not supporting each course of action.**
- **Given the reasons for not supporting each course of action, identify the ethical principles that would be compromised if each action were taken.**
- **Formulate a justification for the superiority of one of the two courses of action by processing all information from the previous five steps.**

### Application of the Ethical Decision-Making Model:

*Case Study*

**Ms. A, a 25-year-old woman, is mandated to treatment after her second arrest for driving while under the influence of alcohol (DUI) in 6 years.**

**The referring agency operates within the disease concept of alcoholism and strongly encourages Ms. A to adopt an abstinence-only treatment goal. Ms. A has no prior history of drug use or alcohol-related problems other than driving while intoxicated. Her first DUI occurred during her senior year in high school, and the current offense occurred after a company holiday party. On each occasion, the client's breath alcohol content (BAC) was between .10 and .13, and the client claimed that she made a conscious effort to stop drinking a few hours before driving home on each occurrence.**

**Ms. A is the daughter of two alcoholics and recognizes the danger in her use of alcohol, and she has been active in Adult Children of Alcoholics (ACOA) meetings at her church for more than 3**

years. She is employed, single, and heavily involved in her local church. Ms. A admits to having used poor judgment. She feels that she does not have a drinking problem and that an abstinence-only treatment goal is both unrealistic and unnecessary. Instead, she would like to adopt a treatment goal that does not involve total abstinence.

### Case Study Analysis

Consider the following application of the ethical decision-making model to the case of Ms. A:

*1* Review the case situation and determine the two courses of action from which one must choose.

*Course of Action A*—Support the client's wish to adopt a different treatment goal.

*Course of Action B*—Mandate the treatment goal of abstinence.

*2* List the fact-based reasons for supporting each course of action.

*Course of Action A*

- Client may continue in treatment.
- Respect the client's desired treatment goal.
- Client is relatively young and presents limited history of alcohol-related problems.
- Incidents involving alcohol appear to be contextually related (eg, senior year in high school, holiday parties).

*Course of Action B*

- Client may experience additional repercussions from continued alcohol use.
- Adhere to agency treatment philosophy.
- Client presents problematic behavior, as indicated by the legal consequences of her alcohol use.
- Client is a child of two alcoholics and, thus, presents an increased disposition to developing a substance abuse problem.

*3* Given the reasons supporting each course of action, identify the ethical principles that support each action.

*Course of Action A*: Autonomy

*Course of Action B*: Beneficence

*4* List the fact-based reasons for not supporting each course of action.

*Course of Action A*

- Counselor may experience difficulties at work for going against agency philosophy.
- Client may experience additional repercussions from continued alcohol use.

*Course of Action B*

- Respect the client's right to choose a treatment goal.
- Client may leave treatment.

*5* Given the reasons for not supporting each course of action, identify the ethical principles that would be compromised if each action were taken.

*Course of Action A*: Beneficence

*Course of Action B*: Autonomy

*5* Formulate a justification for the superiority of one of the two courses of action by processing all information from the previous five steps.

The ethical principles involved in the case of Ms. A are autonomy and beneficence. First, the client's choice of treatment is restricted based on beneficent actions. In other words, the agency/counselor may feel that the client is denying the existence of a problem, which

coincides with the agency's definition of alcoholism within the disease model. Accordingly, the counselor may not be willing to respect the client's wish for an alternative treatment goal because he or she wants to promote the client's well-being. From the agency's point of view, a treatment goal of abstinence is more likely to protect the client from future alcohol-related incidents than one that allows any consumption of alcohol. Second, in adhering to the philosophy of the agency, the counselor may feel pressured to conform to agency practice and advocate the abstinence treatment goal, thereby restricting the services provided. The client, however, should be allowed to adopt an alternate treatment goal. This decision is based on the fact that the agency/counselor should respect the client's autonomy in the decision-making process. Additional reasons for this course of action include the following: (1) the client is relatively young and has no alcohol- or drug-related incidents other than multiple DUI convictions; (2) the client presented "responsible" drinking behaviors (e.g., she stopped drinking hours before driving); (3) the client appears to be an active member of her community and has a stable support system; and (4) the client stated that abstinence was unrealistic and unnecessary, and if it were forced on her, she might become noncompliant or discontinue treatment.

Therefore, Course of Action A (i.e., therapy that includes behavioral modification strategies) should be chosen for this client.

## Conclusion

The case presented here only begins to touch on the numerous potential ethical dilemmas that substance abuse professionals may encounter in practice. For example, issues of justice or the allocation of resources and services may conflict with the counselor's attempt to respect the client's autonomy. In addition, issues of dual relationships, mandatory drug testing, the counselor in relapse, and confidentiality (to name just a few) may arise. As White has stated, "Ethical issues fester in the silence of denial until they detonate into humiliating exposés of our personal and institutional shortcomings."[3]

The substance abuse treatment field is rapidly changing. Treatment facilities are attempting to individualize therapy to meet the needs of a diverse clientele by increasing the menu of treatment options, while more and more counselors are entering the field with less mentoring and limited training in ethics. Ethical practitioners are aware of the contextual forces in the profession that influence their ethical practices. They realize that their own personal values may prejudice service delivery. They have mastered the professional Code of Ethics and are aware of the role that the five ethical principles play in case management decision making. Most importantly, the ethical practitioner has developed the ability to recognize ethical dilemmas and formulate ethically appropriate solutions. Ultimately, the use of an ethical decision-making model can reduce the anxiety and trepidation induced by ethical complexity in rehabilitation counseling and improve counselor competence.

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## Questions Based On This Lesson

*To earn CE credits, answer the following questions on your quiz response form.*

**1. According to this lesson, which one the following statements is *not* correct?**

A. Ethics is often viewed as personal and based on each practitioner's sense of morality.

B. The substance abuse profession appears to be changing rapidly to include a diverse group of practitioners who originate from a variety of academic disciplines.

C. Ethical dilemmas in practice do not appear to be increasing, yet more practitioners are demanding ethics training for liability reasons.

D. Ethical principles are the foundation of any code of professional conduct.

**2. According to the author, problems in substance abuse counseling due to "Realpolitik" include all of the following, *except*:**

A. The pressure to conform to beliefs of etiology and treatment modalities.

B. A contradiction in a clearly defined set of standards.

C. Feelings of anxiety and apprehension when considering confrontational treatment options.

D. An increase in treatment options.

**3. According to the author, societal values that can affect service delivery in substance abuse counseling include all of the following, *except*:**

A. The perception of responsibility for acquiring the substance abuse problem.

B. The degree of independence and productivity in the workforce.

C. Whether the person is coping with or succumbing to the condition.

D. The perception of a threat that substance abusers impose on society.

**4. Which of the following statements is *not* correct?**

A. Professional codes of conduct serve to guide professional behavior and protect clients.

B. Most codes of professional ethics share the same basic principles.

C. Allowing a client to have a voice in his or her treatment is an example of the ethical principle of autonomy.

D. Counselors should adhere to their own personal ethical code when faced with an ethical dilemma in practice.

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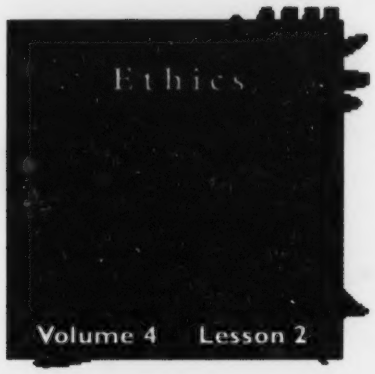


# Ethical Dilemmas in Multicultural Counseling

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## Introduction

Can ethical principles and standards generated in one cultural setting be appropriately applied to persons in contrasting cultural settings? Counselors with a multicultural perspective too often face the dilemma of having to choose between working in an ethical manner or following the "ethical standards" of professional counseling associations.

Wrenn[1] pointed out the danger of cultural encapsulation to counseling as a profession. Cultural encapsulation occurs when we (a) define reality according to one set of cultural assumptions; (b) become insensitive to cultural variations among individuals; (c) assume that our view is the only real or legitimate one, (d) ignore proof that might disconfirm our own unreasoned assumptions; (e) prefer a technique-oriented job definition to more holistic approaches; and (f) refuse to accept responsibility for the consequences of a culturally encapsulated professional identity. Wrenn[2] pointed out that cultural encapsulation continues to be a problem for counseling.

The reasons for encapsulation are clear. First, racial-ethnic minorities are underrepresented in clinical and counseling psychology as well as other counseling-related professions. Second, the under-representation is greatest in academic settings where counselors are trained, and the few ethnic minorities included are usually lower in academic rank. Third, articles about culturally different perspectives are under-represented in professional journals, and professional presentations about culturally different perspectives are rarely given at meetings of professional counseling associations. Fourth, culturally "different" perspectives have been narrowly defined and perceived as exotic rather than as one aspect of all counseling relationships.

Casas[3] suggests that a trend toward ethical consciousness about multicultural issues has emerged for five reasons. First, there is a pragmatic understanding and acceptance of demographic changes and socioeconomic political events that give ethnic minorities more power. Second, ethnic minority groups are now more visible in the media. Third, civil rights legislation has enforced the legal rights of ethnic minority groups. Fourth, there are economic incentives for majority-culture counselors to attract ethnic minority clients. Fifth, multiculturalism is being defined inclusively for demographic groups, status groups, and affiliations as well as for groups defined by ethnicity and nationality.

The civil rights movement of the 1960s resulted in agitation for equal access to mental health care and other services. Movements supporting feminism and opposing the Vietnam War and discrimination against people according to age, disability, or other differences increased an awareness about equity. By the 1970s, underutilization of counseling by minority groups had become a serious concern. Underutilization was usually credited to cultural barriers of language, class-bound values, or culture-bound attitudes in the counseling profession.[4]

By the 1980s and 1990s, the migration of immigrants and refugees highlighted an overburdened and undertrained counseling profession. According to the "melting pot" metaphor, these immigrants were expected to give up their old ways and "become Americans." **Assimilation has not worked because it requires minorities to give up too much of their identity; and integration has not worked because it has led to some persons being "more equal" than others through the domination of less-powerful groups.** Multiple ethnic colonies would fragment society into competing forces. The delicate and perhaps idealistic alternative of pluralism emphasizes both the similarities and differences of cultural groups by continuing the group's self-identity but also finding common ground of shared socioeconomic and political interests. **The alternative to pluralism of assimilation** (relinquishing identity), **integration** (joining the dominant culture), **deculturation** (giving up one's culture), **or rejection** (segregation) **are not acceptable options.**

## Rationalizing Cultural Differences

Sue and Sue[5] describe the many ways that the social sciences have attempted to rationalize ethnocultural or racial differences across cultures and explain why members of some groups are apparently more successful than others. None of the following rationalizations for cultural differences have been satisfactory: (1) **The biological-racial explanation attributes differences to inherited genetic codes, assuming that biological factors and not sociocultural factors influence an individual's success;** (2) **The physiological-medical explanations highlight "deficiencies" in diet and physiological development resulting from poverty that contribute to an individual's success or failure, assuming that these poverty-related deficiencies are nonreversible;** (3) **The demographic-environmental explanations attribute differences to environmental conditions such as a warm or cold climate, with lower levels of success being related to persons living in tropical areas;** (4) **The psychological-individualistic explanations attribute success or failure to the individual's motivation, self-image, ability to delay gratification, achievement expectancy, and other individualistic factors;** (5) **The sociological-status explanations have attributed success or failure to the group's sociocultural status and record of achievement through social networks where the rich get richer and the poor get poorer.** Each of these explanations presents a partial explanation of cultural differences, but not one of these explanations alone is sufficient. Each explanation assumes an objective standard of success, as typically defined by the more powerful dominant culture. Each explanation assumes a self-reference criterion by the more powerful dominant culture to explain the success or failure of other cultures. Each explanation ignores significant aspects of the complicated cultural context necessary to define, understand, and explain success and differences.

## Moral Exclusion

Moral exclusion is the consequence of cultural encapsulation, occurring sometimes unintentionally and sometimes through malicious intent. Opotow[6] lists many rationalizations and justifications of moral exclusion, including psychological distancing, displaced responsibility, group loyalty, and the normalization or glorification of violence. Moral exclusion leads to the escalation of cultural conflict. "As severity of conflict and threat escalates, harm and sanctioned aggression become more likely. As harm-doing escalates, societal structures change, the scope of justice shrinks, and the boundaries of harm-doing expand."[6]

## Unintentional Racism

Moral exclusion is not always intentional. **Ridley[7] has identified six examples of unintentional racism. First, some counselors seek to avoid the issue of cul-**

**tural differences by claiming to be "color blind," treating everyone alike. Avoidance frequently indicates a high level of discomfort or insecurity about discussing cultural differences in the individual case.[7] Second, counselors who are too "color conscious" attribute all problems to a client's cultural background out of guilt for oppressed minorities, and often fail to separate pathology from cultural background. Third, clients may transfer their own positive or negative feelings based on experiences with persons "like" the counselor, and the counselor may fail to recognize the countertransference. Fourth, counselors may "need to be needed" by a culturally ambivalent client and facilitate a codependency relationship. Fifth, the client may respond defensively to a counselor's own unexamined or stereotypical racism, thereby causing misattribution by the counselor. And sixth, counselors may misinterpret culturally learned patterns in clients, such as the unwillingness to self-disclose private information.**

**Goodyear and Sinnett[8] identify other examples of how counselors might unintentionally violate a client's culture by** (a) **misunderstanding who the client is;** (b) **lacking information or skills for working with a special population;** (c) **following prejudiced attitudes and values in assessment and treatment;** (d) **being unable to communicate the consequences of assessment or treatment appropriately to a culturally different client; and** (e) **failing to actively protect the client against abuses of authority by social institutions.** LaFromboise, Foster, and James[9] include other examples of implicit institutionalized bias resulting in culturally different populations being underserved by uninformed or misinformed counselors.

## The Institutionalization of Cultural Bias in Counseling

Even measures of moral development themselves are biased. Snarey[10] discovered that Kohlberg's theory of moral development reflected an individualistic bias inappropriate for collectivist cultures. Segall, Dasen, Berry, and Poortinga[11] concluded that the Kohlberg model of moral development reflects the values of urban, middle-class groups. In addition, Gilligan[12] discovered a Kohlberg bias toward the male viewpoint.

Indeed, the dangers of cultural bias have been recognized. In 1971, the Committee on International Relations in Psychology for the American Psychological Association (APA) established a subcommittee on ethical considerations of cross-cultural research. The committee discovered that the benefit to the researcher was much clearer than the benefits to a host culture. Taft[13] claimed that most research psychologists are so "psychologecentric" that they regard themselves as having the right to mine data from the places where they need it, provided they pay royalties to the natives (often, incidently, in accordance with their own arbitrary concept of what is fair compensation) and provided they do not destroy the ecology irreparably. "In the latter respect, we are often not really much more conscientious than is the typical multinational mining company".[13] The Vail Conference in 1973 declared that counselors who were not aware of their client's culture were behaving unethically. The Dulles Conference in 1978 continued this concern by creating guidelines for cooperation across cultures and by setting up the Minority Affairs Office at the APA. By 1979, the APA accreditation criteria demanded cultural diversity among faculty and students.

### Cultural Bias in Accreditation:

Kitchener[14] rightly notes that we are better at identifying the ethical issues that face us than at thinking through how to resolve them. The APA Accreditation Criterion II on cultural and individual differences provides an example of this difficulty. This mandate is described in rather vague language that lends itself to inconsistent and idiosyncratic interpretation. The criterion declares that, in an approved counselor education program of study, attitudes of social responsibility and respect for cultural differences must be imparted to students. Also, social and personal diversity of faculty and students must be an "essential goal," and programs must develop knowledge and skills relevant to human diversity. Rickard and Clements[15] are critical of these guidelines for being ambiguous. They recommend developing more detailed guidelines, mentioning legally mandated affirmative action alternatives, sepa-

rating individual differences from cultural diversity issues, and ranking-ordering categories of human variability (e.g., age, gender, lifestyle) as they change over time. Each program can be made responsible for developing specific objectives, and incorporating data from each program as evidence of compliance. In the absence of more specific guidelines, the ambiguously stated standards tend to protect the status quo.

### Cultural Bias in the APA Ethical Guidelines:

A review of the APA and the American Counseling Association (ACA) Ethical Guidelines demonstrates other examples of possible implicit cultural bias. Pedersen and Marsella,[16] LaFromboise and Foster,[9] and others, have criticized the professional guidelines for ethical behavior for being culturally encapsulated. **Ethical guidelines appropriate to one cultural context are not likely to be as appropriate in contrasting cultural settings. To the extent that ethical guidelines are based on the values of one dominant culture, they need to be modified.** To the extent that a single standard of normal, healthy, and ethical behavior is favored, clinicians must recognize alternatives. To the extent that ethical guidelines are technique oriented, they should be humanized.

## Ethical Principles of the APA Guidelines

**The Ethical Principles of Psychologists and Code of Conduct[17] tend to be generalized "aspirational" goals.** Consider this: Principle A requires psychologists to stay within their areas of competence, which is difficult (and, some might argue, largely ignored) in multicultural settings; Principle B requires psychologists to be aware of their own belief systems, values, needs, and limitations, which presumes a high level of multicultural awareness; Principle C requires psychologists to uphold their professional and scientific responsibility by adapting their methods to different populations, which would presume limited, or no, tolerance for cultural bias; Principle D requires respect for people's rights, dignity, and worth across differences, which would make multiculturalism a much more central issue than it is at the present time; Principle E emphasizes a concern for others, noting the importance of power differences across populations; Principle F emphasizes social responsibility for human welfare as an ideal, emphasizing the quality of justice. **Most criticism has presumed that the principles themselves are valid although vague and general. The criticism focuses on standards for applying these principles.**

## Standards of the APA Guidelines

Standard 1.08 of the APA guidelines on human differences states, "Where differences of age, gender, race, ethnicity, national origin, religion, sexual orientation, disability, language or socioeconomic status significantly affect psychologists' work concerning particular individuals or groups, psychologists obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services or they make appropriate referrals." The patronizing and conditional language seems to presume that these differences are not always important, in spite of abundant research to the contrary.

Standard 1.10 on respecting others states, "In their work-related activities, psychologists do not engage in unfair discrimination based on age, gender, race, ethnicity, national origin, religion, sexual orientation, disability, socioeconomic status, or any basis proscribed by law." The implication that discrimination against any of these groups might, under some conditions, be considered "fair" is again inconsistent with the general principle.

Other standards such as 1.17, which prohibits multiple relationships, or 1.18, which limits barter with clients, clearly disregard real patterns in cultures that are more dependent on collectivistic relationships or less dependent on a money economy.

**The second set of standards requires accurate assessment** (2.01)**, the appropriate use of assessments** (2.02)**, and adapting assessment norms to different populations** (2.04)**.** This set of standards ostensibly disregards the research documenting cultural bias in tests and measures. Neither the third set of standards on public statements, the fourth set on therapy, nor the fifth on privacy and confidentiality mentions cultural categories. However, the fact that the fifth set on pri-

vacy and confidentiality does not mention cultural categories may appear to be a culturally loaded issue. The sixth set of standards also disregards the importance of multicultural education and training of counselors and psychologists.

If the problem is not the principles but their appropriate application in practice, then this should be stated in the standard on education and training. Cultural differences are not mentioned in the seventh set of standards on forensic activities or in the eighth set of standards on resolving ethical issues; this implies a "one-size-fits-all" perspective of psychology in general and counseling in particular.

## Cultural Bias in the American Counseling Association Ethical Standards

The ACA Standards of Practice and Ethical Standards also fail to reflect the diversity of cultural contexts according to race, ethnicity, socioeconomic, gender, and other differences in its revision of the 1988 standards.[18] Ponterotto and Casas[19] were critical that the 1988 standards only had four direct references to culture, and these emphasized the "prevention of harm" rather than any obligation to assist and help persons from different cultures. That accusation would also apply to the 1993 introductory "Standards of Practice" and to a lesser extent to the "Ethical Standards" that follow. The weakness of the ACA standards are of a consistent cultural bias similar to those weaknesses cited earlier in the APA ethical standards.

**First, there is a bias toward an individualistic perspective that will be less appropriate for more collectivistic cultures.** In SP.4., collectivist cultures would have a difficult time excluding dual relationships that might be desirable or even essential to appropriate caregiving. Likewise, in SP.13., separating the rights of individuals from the responsibility of the family will be difficult in family-oriented cultures. It is difficult to escape from the individualistic bias. Even the primary obligation "to respect the integrity and promote the welfare of clients" mentioned in A.1. of the Ethical Standards lends itself easily to an individualistic interpretation without further interpretative guidelines.

**Second, there is a bias toward the culturally different client accommodating her- or himself to a standard of behavior defined by a majority culture.** What are the indicators that a client has been "adequately informed" in SP.2. of the Standards of Practice? Is it necessary for the client to also comprehend the information being transferred and, if so, by what criteria? Likewise, in SP.16., is disguising the data source sufficient or should the client's permission also be required? Is the usefulness of data more important than getting a client's permission to use those data? In SP.18., who defines the "limits" of a counselor's competence necessary for ethical practice? In SP.19., what constitutes adequate continuing education? In SP.21., does accuracy imply not only the accurate sending of an advertising message but also the accurate (isomorphic) receiving of that same message?

**Third, there is an elitist bias based on the more powerful care providers' obligation to protect the profession.** In SP.24., limiting the use of the term "doctor" to counselors or "closely related" professions seems to disregard the historical fact that disciplines other than counseling have frequently been more responsive to multicultural needs than have counselors. I would think that a provider needs to accurately identify credentials to the client and verify that the client accurately understands those credentials regardless of the disciplinary background of that provider. In SP.43., where "professional" counselors are obligated to see that their students and supervisees get remedial attention when necessary, the same obligation is not applied to colleagues and peers who also may require remedial attention.

**Fourth, there is an assumption that dealing with cultural issues is relatively simple and can be done objectively.** In SP.34., the simple admonition to use assessment instruments "appropriately" is so general it has no meaning at all until we know who defines what is appropriate. In SP.35., is merely informing the client about the nature and purpose of testing enough or should the client comprehend that information? Throughout the Standards of Practice and Ethical Guidelines, the authors have tried to avoid controversy by being very general with their criteria. There is an implicit assumption that all colleagues of goodwill understand the guidelines in the same way, although that is most certainly not true. While some different cultures are mentioned, there are many others that are

disregarded such as language groups or physically disabled populations. Does this imply that groups not mentioned are not important? There is a frequent mention of "respecting differences" without regard to "respecting similarities" at the same time, as though a liturgical acknowledgment of differences will protect the standards from bias or criticism.

**Fifth, there is an assumption of absolute standards of right and wrong that disregards the variety of different cultural contexts for both providers and consumers.** In SP.8. and later, there is a constant reference to "professional counselors," which implies that these standards do not apply to "unprofessional counselors." Is this a redundancy in the use of language or an example of the provider's viewpoint being primary? If the client makes the determination that the counselor is unable to be of professional assistance to him or her, would the termination also be appropriate, even when the counselor did not share the client's viewpoint? Do both counselor and client have to be hopeful for counseling to be continued? Since most counselors come from dominant cultures and clients from minority cultures, this becomes a multicultural concern. In SP.36., the need to provide culturally appropriate interpretations of culturally biased tests is a very important standard. If we begin by assuming that all tests are to a greater or lesser extent biased, then compensating for that bias through skilled interpretation is extremely important even though not mentioned in that standard. In SP.42. and elsewhere in the standards, counselors working through interpreters or when there is a language problem would be hard-pressed to guarantee that the client's rights are not compromised. SP.44. seems to imply that class- or coursework should not contribute toward self-growth or require self-disclosure for that coursework to be graded or evaluated. This standard seems to presume a scientific objectivity that minimalizes personalized subjectivity. In SP.47., what one culture considers reasonable precautions to avoid causing injury will be different from that of a different culture. Who decides what is reasonable?

There is an underlying assumption throughout these standards that what is good for the counselor is good for everyone. Like other "one-size-fits-all" perspectives, this assumption is subject to error. Client populations sometimes underutilize counseling—even good counseling—because it has a resocialization effect that alienates their young people from the traditional culture. This may be true even though the effects of counseling might be judged "positive growth" by external standards. There also seems to be a bias toward the medical model and away from the educational model throughout the standards in the language used and the implications. It should be important to acknowledge the appropriate role of both the medical and the educational model from their different perspectives.

## The Consequences of Culturally Encapsulated Ethical Standards

In both the APA and the ACA ethical guidelines, issues of cultural diversity are mentioned as the exception to the rule, requiring some adaptation of or accommodation to normal policy. Counselors are encouraged to become better acquainted with culturally different people, but knowing more about other cultures or even the counselor's own culture is not sufficient to guide ethical behavior toward other cultures. The implicit and paternalistic implication is that "other" (minority) cultures are exotic alternatives. The guidelines arguably seek to protect the professional counselor against other cultures at least as much as protecting other cultures against the counseling professional. Because so many of these presumptions are implicit, they are difficult to detect and/or change.

Even when the professional counseling association is well intentioned, it functions in a culturally encapsulated framework of assumptions that essentially constrain real equity. For any ethical standard to work, the basic underlying philosophical assumption must be identified, challenged, and clarified so that counselors will not need to choose between ethical behavior and professional obligation. Self-criticism by concerned professionals will assist in overcoming the dilemma of multicultural counseling and the barrier of implicit but fundamental assumptions that function as moral absolutes in defining ethical obligation.

## Relational Alternatives as Ethical Standards

Ivey[20] advocates a more relational view of ethics in the client's cultural context as the cultural context of the

counselor, client, and problem are dynamic and constantly changing. As an alternative to rigid and absolute guidelines, a relational view interprets standards of ethical behavior according to the network of consequences for everyone involved. Each ethical standard may need to be interpreted and applied differently in each cultural context. The definition of "fair treatment" will need to be interpreted differently in each cultural context to reflect the characteristic of fairness. Moral problems are viewed differently across cultures and therefore must be dealt with differently without resorting to relativism. **Relativism as ethical egoism** (what's right for one person may not be right for anyone else), **ethical egotism** (right is a function of reconciling each person's beliefs, and nonbelievers are wrong), **ethical nihilism** (there is no meaning to moral concepts), **or cultural relativism** (right and wrong are determined solely by the culture of the individual) **inhibits moral discourse and social accord.**

On the other hand, absolute standards impose one viewpoint on all others and are clearly undesirable. If we judge behavior according to how it achieves "the greatest good for the largest number," minority group members are again required to conform. If we judge behavior in terms of the person's intentions, then unintentional violations are ignored.

Shweder, Mahapatra, and Miller[21] review three contrasting theories of moral development from a constructivist perspective. First, Kohlberg's cognitive-developmental theory bases moral obligation on conventional or consensus-based obligation rooted in convention at the lower stages and natural law at the higher stages of development. Second, Turiel's social-interactional theory separates morality from convention. Moral obligation is derived from social experiences related to justice, rights, harm, and the welfare of others. A third social communication theory combines Kohlberg and Turiel, basing moral obligation on the learned cultural context that does not depend on consensus or convention or universals across cultures. The third theory differentiates between mandatory and discretionary features of moral obligation. A rational moral code would presume both that there are mandatory and absolute measures of goodness in principles of natural law, and accepted criteria of justice in the abstract and that these absolute measures are frequently encapsulated by the dominant and more powerful cultural group's perspective in the practical concrete application of those abstract principles. A relational alternative recognizes the importance of absolute but abstract ethical principles and at the same time the multiplicity of applications in complex and dynamic cultural contexts to reflect both cultural similarities and cultural differences at the same time. The "one-size-fits-all" application of ethical standards is clearly unacceptable in a global society where the same basic values and ethical standards are necessarily different in their expression.

## Conclusion

We need a more pluralistic perspective in form and function to accommodate a range of assumptions while acknowledging the common ground of shared interests. Such a more-inclusionary perspective will allow ethical behavior to be interpreted within a cultural context that includes both majority and minority perspectives. Behavior judged outside of the cultural context in which it occurs cannot be assessed or judged accurately.[22] Ethical standards that take an inclusionary perspective and judge behaviors in their cultural context are likely to be more equitable, enforceable, and meaningful for the ethical provider of psychological services.

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## Questions Based On This Lesson

*To earn CE credits, answer the following questions on your quiz response form.*

5. **Gilbert Wrenn described "cultural encapsulation" as:**

   A. Becoming insensitive to cultural variations among individuals.

   B. Defining reality according to one set of cultural assumptions.

   C. Assuming that our view is the only real or legitimate one.

   D. All of the above

6. **Ridley's description of examples of unintentional racism includes all of the following, *except*:**

   A. Seek to avoid the issue of cultural differences.

   B. Lack color consciousness.

   C. Fail to transfer their own positive or negative feelings.

   D. Protecting the client against abuses of authority by social institutions.

7. **The APA ethical guidelines:**

   A. Tend to be generalized aspirational goals that may not be realized in actual practice.

   B. Should be discarded.

   C. Demonstrate how the dominant culture exploits its advantage over minorities.

   D. Are based on principles that are not valid.

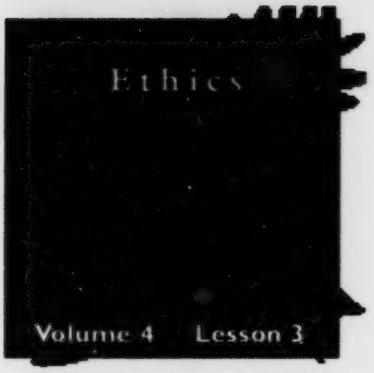
8. **Which of the following statements regarding the ACA ethical guidelines is *not* correct?**

   A. They do not make enough references to cultural groups.

   B. They are biased toward an individualistic perspective that is less appropriate for more collectivistic cultures.

   C. They are biased toward culturally different clients accommodating themselves to a standard of behavior.

   D. They should be discarded.




# Ethics: Philosophical Roots—Practical Implications

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## Introduction

Because professional ethics is something of a growth industry, this lesson begins by exploring the widespread interest in the area of applied, professional ethics and discusses possible reasons for this attention. The overall intention of this lesson is to give the practicing mental health professional exposure to some of the dominant Western philosophical positions fundamental to the academic discipline generally referred to as ethics. While professional ethics classes and seminars are quite common, courses and texts often neglect the history and tenets of basic moral reasoning. Additionally, they often fail to challenge practitioners to consider the theoretical bases upon which they make their day-to-day ethical decisions. These omissions contribute to the reactive state of professional ethics codes. A more deliberate foundation might help mental health professionals reason ethically and proactively about the duties and moral parameters of their chosen field.

Humans have long been guilty of ignoring the richness and wisdom available in multiplicity and diversity, choosing instead to fear, degrade, or ignore that which is and those who are different. This lesson will, of necessity and regrettably, only focus on three philosophical perspectives, all of which are solidly lacking in cultural diversity and reflect the biases and limits of their times and authors. Many faith traditions and theocentric cultures have ethical perspectives informed by a relationship to a creator or creative force.[1] Feminist thinkers have contributed significantly to our understanding of moral development and ethics.[2,3] Cultural views of right and wrong, of the good life, and of virtue are all central to the very core any given culture and each view deserves close scrutiny as we strive to be culturally appropriate and sensitive.[4,5] Thus, this lesson only begins an important process—that of contemplating some of the roots or origins of ethical rules or systems. Ethics codes for the majority of mental health professionals in the United States, Canada, and Europe reflect the cultures in which they were developed. Examining the philosophical positions most closely associated with those cultures is a good place to start, but decidedly *not* a good place to end.

## Why All This Fuss About Ethics?

There are at least three reasons for the current focus on both applied and philosophical ethics. First, from engineering to medicine, from social work to nuclear physics, professionals have come to realize that knowledge of their particular subject matter is not enough. We are all increasingly aware that the application of any knowledge entails judgments that have moral dimensions. Wheatley[6] wrote the following in her book on business leadership:

> **And ethical and moral questions are no longer fuzzy religious concepts but key elements in our relationships with staff, suppliers, and stakeholders. If the physics of our universe is revealing the primacy of relationships, is it any wonder that we are beginning to reconfigure our ideas about management in relational terms?**(p.12)

As Wheatley suggests, the belief that there is no such thing as value-free knowledge has become much more widespread. From quantum physics to education, from business to computer science, instructors and practitioners are recognizing the inter-relatedness of their work to the overall quality of life on the planet.[7,8]

**Rest[9] has pointed out that any action that has the potential to affect another person's well-being requires a moral judgment.** As such, morality infuses most professional and personal aspects of daily life. Mental health service provision entails the enactment of knowledge that, by its very nature, has the potential to affect another person's well-being. As Alan Tjelveit[10] points out in his thought-provoking book, *Ethics and Values in Psychotherapy*, ". . . all therapy involves value-laden goals."(p. 4)

A second reason for the growth of interest in professional ethics is that philosophers have reclaimed their role in helping society determine ethical courses of action in the applied world. As Peter Singer[11] recounts, moral philosophers, as concerned citizens, have begun to recognize the relevance of their traditional training and to offer it in various settings. Their contributions have been, for the most part, well received by the broader community. According to Singer:

> **To an observer of moral philosophy in the twentieth century, the most striking development of the past twenty years would not be any advance in our theoretical understanding of the subject, nor would it be the acceptance of any particular ideas about right and wrong. It would rather be the revival of an entire department of the subject: applied ethics.**(p. 733)

Professional organizations such as the Association for Practical and Professional Ethics have sprung up, and students can major in ethics at the undergraduate and graduate levels. Students of moral philosophy and many moral philosophers are willing to offer their theories and methodologies to serve professionals and organizations wishing to make sound ethical decisions. Some philosophers currently provide individual consultation or counseling sessions for people who wish to find or sharpen their own sense of meaning, morality, and life direction. Further, there are psychologists who point out the necessity of moral deliberation (a hermeneutic alternative) in providing counseling services:

> **. . . a hermeneutic perspective would encourage psychology to understand humans as moral and historical beings, rather than as the human equivalent of machines that can be best refashioned and "tuned up" through the use of technicist procedures produced by physical science methodology. This would necessitate conceiving of therapy as a kind of moral discourse that attempts to aid in developing what Heidegger thought of as an encounter with mortality and an examination of the moral trajectory of one's life.**[12] (p. 993)

Though not as high-minded or admirable to admit, a third driving force behind the increasing attention to professional ethics has been the expanding litigiousness of our culture. Behaviors considered to be unethical has, in some cases, also become illegal. Further, in civil suits, professionals who simply behave in a way that most others in the field would consider wrong, inappropriate, or unethical may be found liable for their actions. Therefore, professionals who are neither passionate about using their knowledge for the highest

good nor wish to engage in deep debate over the moral dimensions of their work, might find themselves interested in professional, applied ethics for a most pragmatic reason: self-defense. They may comply with their professional codes, even if they do not agree with them, simply because failure to do so could prove to be quite costly.

## The Role and Limits of Ethics Codes

Concurrent with the interest in applied ethics has been the proliferation of ethics codes by multitudes of professional associations, political bodies, corporations, and nonprofit organizations.[13] The development of these written documents has proceeded in a variety of fashions and the resulting codes vary enormously in level of abstraction, length, breadth, specificity, and orientation. **These codes, and their close cousins, "Standards of Practice," are intended to serve as guides for professional behavior by members of a given profession or organization.** In addition, **they serve to alert the general public as to what might be expected of these members.**

This proliferation of professional ethics and codes has not been without its critics. In an article entitled "Ethics codes spread despite skepticism" in the *Wall Street Journal*, Bennett,[14] notes that many critics consider the development of codes mere window dressing. Codes look good, but in fact make very little difference in actual professional behavior. Bennett's interviewees cited many instances of code-engendered double binds and perceived hypocrisies.

Further, there is the curious paradox , heightened by our litigious society, which is a corollary to the adage, "If it isn't written down, it didn't happen." This paradox could be roughly stated as, "If it is written down, and you screw up (even unintentionally), you are doubly damned." For example, one small, nonprofit agency struggled for months to write a code of expected behaviors for employees. This code ranged from exact descriptions of expected staff behavior in the event of exposure to bodily fluids to expected staff behavior in greeting incoming clients. The document was detailed, thorough, and explicit. When the directors proudly presented it to their attorney for her inspection, she told them to burn it. She instructed them, instead, to have very general policies, to conduct ongoing training on basic professional expectations, and then to trust people to use their best judgment in specific situations (Bolstad, personal communication, May, 1989). If an exact formula is written down, then even an intelligent and morally correct action, should it deviate from the written rules, will require significant justification.

Regardless of their detractors and perils, codes continue to be developed. Their clarity, adequacy, and relevance, however, vary greatly. **Frankel[15] states that there are three types of codes: aspirational, educational, and regulatory. The aspirational aspect of an ethics code concerns itself with establishing a vision for professionals functioning at their highest moral potential. The educational dimension addresses the fundamental needs and ongoing identity development of the practitioner striving to make morally sound decisions. The regulatory function serves to define limits and the resultant consequences of violating those limits.** Professional codes and Standards of Practice are most helpful when they are organized so the practitioner can identify which elements of the code are aspirational, which are educational, and which are mandatory and carry consequences if violated.

The vast majority of the focus in professional ethics textbooks is devoted to specific behavioral edicts, mandates, and guidelines. Scant, if any, attention is given to the more general foundational aspects of moral reasoning or the cultural dimensions of this foundation. Given the time constraints in most professional schools and graduate programs, this may be understandable, but such an approach puts the proverbial cart before the horse. The issues related to how and why each profession decides the moral parameters of their enacted knowledge base seem as important as the resulting rules. As Corey, Corey, and Callanan[16] state in their book *Issues and Ethics in the Helping Professions*, "Laws and ethics codes, by their very nature, tend to be reactive, emerging from what has occurred rather than anticipating what may occur."

This does not need to be the case. Given adequate background, professionals can understand the source of the ethical concerns and rules in their professions, and can thereby engage in proactive, preventative reasoning and ethical application.

## 2000 Years at a Glance

Nearly 20 years ago, Daniel Callahan,[17] founder of the Hastings Center (Institute of Society, Ethics, and the Life Sciences), wrote the following:

> **At least for those teaching applied and professional ethics, nothing would seem more important than developing the skills necessary to move out of the comforting circle of professionalism into a world of more general discourse. That much said, I would nonetheless underscore a strong point: whatever the literary or other failures of moral philosophers, those coming to ethics from other disciplines must wrestle with their writings. They should feel free to rail against the jargon and the apparent irrelevance on many occasions to most human lives; but the works must be read, and the best of them should be included in the syllabi of courses in applied and professional ethics.**(p. 79)

Exposure to historical and current theories and practices in moral philosophy has the potential of increasing the depth and sophistication of practicing professionals. Therefore, the next section gives an overview of what are often listed as three of the foundational views of Western ethical thinking.[18,19]

Admittedly, attempting to build a foundation in moral reasoning in the context of this lesson is a tall order. In their text on ethics in counseling, Cottone and Tarvydas[20] acknowledge: "It should be noted that many different philosophical positions can be related to counseling. A whole text could be written on ethical philosophy as related to counseling and psychotherapy."(p. 109) Therefore, be advised: this is an extremely condensed version of these positions, and the positions themselves are culturally specific and thereby exclusive of other cultural perspectives. Further reading is essential.

## Deontology, or (as the Nike company used to say): "Just do it"

Immanuel Kant (1724–1804) certainly did not invent the concept of doing one's duty, but he gave the notion a great deal of depth and breadth. Kant was concerned about the ultimate truths and the absolutes in life. **He believed that the best society is one in which all members follow the moral rules because of a sense of duty, not because of the potential for happiness.**[21] Happiness may or may not follow, but the rule must be upheld.[17]

His famous edict, which he defined as a categorical imperative (neither hypothetical nor optional), can be paraphrased as follows: Act that you can will your action to become a universal law for all humankind. Most of us are more familiar with the words our parents often used, "What if everybody acted like you're acting right now?" Basically, the challenge is this: Can you honestly say that the action you are considering would be a desirable one for all people, in all places, at all times? If so, it is a morally correct action. For Kant, there was little to be gained by studying either the details of the situation, (details can be manipulated to justify immoral behavior) or the end results of the action (because sometimes very bad moral behavior brings about a happy ending, and sometimes very good moral behavior is not enough to stop a disastrous ending.) One must, at all costs, obey the moral rules that make for a morally superior community. Kant also believed that the harder it was for a poor mortal to do the right thing, the greater the moral credit.

**Another central Kantian moral position is that we should never, ever treat people as simply a means to an end.** Other human beings always deserve to be treated as ends in themselves, not merely a means to our own goals, happiness, or gain. The move toward extreme care in human subjects research reflects this guidance from Kant. Some types of research simply cannot be conducted, no matter how much "good" the findings may bring about. A question that can be asked in this regard is: Would I, as researcher, be willing to be a subject in my own experiment?[19]

## Consequentialism, or the Moral Bottom Line

**Moral positions that give primacy to the end-state brought about by a given set of actions or habits are said to be teleological** (from the Greek telos, meaning end or goal) **or consequentialist in their orientation.**

These positions range from ethical egoism (just make things come out good for yourself) to utilitarian ethics to virtue ethics, which we'll discuss below. **Consequentialists judge the goodness or rightness of a given act by the outcome of the action.**

**Jeremy Bentham** (1748–1832) **and John Stuart Mill** (1806–1873) **were British philosophers who believed that the right way for society to organize itself was utilitarian—that is, that laws, customs, and morals should all be judged by how much happiness or pleasure they bring about.** The best laws or ethics are those that bring about the greatest good for the greatest number. Bentham believed that one could simply do the math and come up with the right actions to maximize pleasure and minimize displeasure. A few years later, Mill refined Bentham's ideas somewhat, assigning higher values to some forms of "good outcomes" or pleasures than others.

Since then, many refinements have been proposed by consequentialist proponents. Some advocate that we judge each act according to its particular outcome, whereas others advocate that we look at the likely outcomes more broadly and make rules that ensure the greatest good. For instance, an act utilitarian might judge stealing some bread for a hungry family to be a moral act. A rule utilitarian would more likely believe that there should be a rule against stealing because in the bigger picture, if everyone stole things, many people would suffer.

The important thing to remember is that consequentialism entails a radical rejection of absolute or duty-based morality. The focus is on accomplishing the best thing possible, given the probabilities. According to Burtness, "The moral act, therefore, is one that projects into the future some good for human beings and for the whole creation to which human beings are inextricably tied."[17 (p. 78)]

## Virtue: The Forgotten Art?

Aristotle was a teleologist in a very specific sense of the word. He was concerned with making truly moral, mature, wise, citizens (unfortunately, he limited his citizenry to free, white males). He believed, somewhat similarly to Carl Rogers, that each individual is born with a blueprint of what he or she should or could become, given the right conditions. He believed that when one applied the necessary discipline, one could discover true happiness in living a virtuous, fulfilled life.[22] Aristotle made a distinction between intellectual virtues and moral virtues. Intellectual virtues come into being through diligent education; moral virtues, by practice, moderation, and habit development. Some of the moral virtues he expounded upon were: courage, temperance, liberality, pride, good temper, friendliness, truthfulness, and ready wit. The following quote provides an example of Aristotle's mandate toward moderation, the Golden Mean:

> **Those who carry humour to excess are thought to be vulgar buffoons, striving after humour at all costs, and aiming rather at raising a laugh than at saying what is becoming and at avoiding pain to the object of their fun; while those who can neither make a joke themselves nor put up with those who do are thought to be boorish and unpolished. But those who joke in a tasteful way are called ready-witted, which implies a sort of readiness to turn this way and that; for such sallies are thought to be movements of the character, and as bodies are discriminated by their movements, so too are characters.**[22 (p.103)]

For Aristotle and for virtue (or character) theorists since, the whole point wasn't the act, but the actor. Character is not defined so much by what one does as who one is and who one is becoming. It is not confined to a specific behavior but focuses on patterns of behavior that reflect an inner core. **This virtuous inner core is developed by practicing, modeling, and exercising the discipline of moderation.** The young person must choose to tell the truth to become an honest person. To become courageous, one must choose to act bravely in the face of challenge. But how does one know which acts qualify as virtuous? Certainly, Aristotle's Golden Mean—or moderation in all things—helps. But further, he recommends finding good role models and following their examples:

Actions, then, are called just and temperate when they are such as the just or the temperate man would do . . . most people do not do these, but take refuge in theory and think they are being philosophers and will become good in this way, behaving somewhat like

patients who listen attentively to their doctors, but do none of the things they are ordered to do. As the latter will not be made well in body by such a course of treatment, the former will not be made well in soul by such a course of philosophy.[22 (p. 35)]

## Examining (and Using) the Roots

**Deontology tends to be rule-bound and firm in its position.** Many of the codes of ethics lean heavily on a deontological approach. **The rules are written in such a way that the practitioner is not asked to determine or even guess at the morality of the outcome, but simply to obey the ethic.** It can be reassuring to professionals that some ethical stances are generally held to be absolute. The prohibition against sexual relationships with clients has attained that status for most. The necessity of obtaining the requisite training and credentials before becoming licensed and practicing independently is also fairly well accepted as an absolute.

There are also many ethical guidelines that draw from a consequentialist worldview. Professionals are held accountable for the outcomes of their actions. Many actions may be ethical in the case of some outcomes, and unethical in the case of others. Keeping family secrets, providing pro bono services, and engaging in dual roles are all possible examples. Professionals need to be able to assess intelligently the likelihood of various outcomes and make the highest ethical choices based on a desire for the best possible outcome. This essential professional duty links directly to the last of the three classical positions: character ethics.

Aristotle's wisdom regarding character development is relevant today. Supervision, mentoring, and ongoing collegial relationships are central in the development of mature, virtuous, mental health professionals. Someone once said, "It is possible to make the same mistake for twenty years and call it rich clinical experience." The journey toward excellence is never over. Not only must we ask ourselves, "How would a truly wise and ethical practitioner handle this?" but we must also seek out guidance and development from such people.

## Conclusions

Ethics codes, even when observed religiously, do not and cannot ensure ethical behavior on the part of the practicing professional.[23] **Codes are a reflection of our current state of development as a profession and culture.** They often lack cultural sensitivity and can sometimes end up more protective of the professional than of the client. Also, codes cannot be written in such detail that all specific situations are covered. Being ethical professionals means being morally accountable for our expertise, actions, and the manner in which we place ourselves at the service of human need.[24] This requires a commitment to ongoing education, professional dialogue, and honest scrutiny of our beliefs, values, and motivations.

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## Questions Based On This Lesson

*To earn CE credits, answer the following questions on your quiz response form.*

**9. If someone said the following, from which classical ethical position would they be arguing:**

*"I'm going to develop an informed consent document that is written very, very simply. It might insult some of my more educated clients, but I see more young people than anything, and I want a document they can really understand."*

A. She would be reasoning from a deontological framework.

B. She would be reasoning from a character or virtue-based framework.

C. She would be reasoning from a consequentialist or utilitarian framework.

D. She would be reasoning from a Socratic position.

**10. "I'm sorry, but I cannot, under any circumstances, work with a client who is dating my sister. It just wouldn't be right. Not ever."**

A. She would be reasoning from a deontological framework.

B. She would be reasoning from a character or virtue-based framework.

C. She would be reasoning from a consequentialist or utilitarian framework.

D. She would be reasoning from a Socratic position.

**11. "I believe the best way to be an ethical counselor is to form close collegial and supervisory relationships with seasoned counselors who everyone agrees to be of high moral stature."**

A. She would be reasoning from a deontological framework.

B. She would be reasoning from a character or virtue-based framework.

C. She would be reasoning from a consequentialist or utilitarian framework.

D. She would be reasoning from a Socratic position.

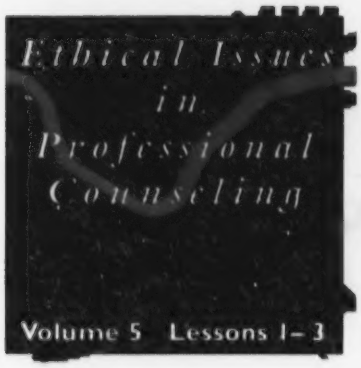
**12. Becoming thoroughly acquainted with your professional ethics code ensures that:**

A. You will always know the ethical thing to do.

B. You will be able to detect the cultural features salient for working with people from other cultures.

C. You will have a glimpse of your own culture's ideas about moral professional behavior.

D. All of the above

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| 9 | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 0 | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

# EVALUATION FORM

*Directions in*

**Program Title:** _____

**Volume Number:** _____

**Full Name:** _____

**Your Social Security Number:** _____ - _____ - _____

**Your Customer Number:** _____

Please rate this program according to the following criteria using the rating scale below. (**5** = excellent, **4** = good, **3** = satisfactory maybe, **2** = needs improvement, **1** = poor)

| | | 5 | 4 | 3 | 2 | 1 |
|---|---|---|---|---|---|---|
| 1. | Quality of Writing | ○ | ○ | ○ | ○ | ○ |
| 2. | Timeliness of Topics | ○ | ○ | ○ | ○ | ○ |
| 3. | Ease of Use | ○ | ○ | ○ | ○ | ○ |
| 4. | Relevance of Practice | ○ | ○ | ○ | ○ | ○ |
| 5. | Learning Objectives Achieved? | ○ | ○ | ○ | ○ | ○ |
| 6. | Clarity of Learning Objectives | ○ | ○ | ○ | ○ | ○ |
| 7. | Impact on Practice | ○ | ○ | ○ | ○ | ○ |
| 8. | Price of Program | ○ | ○ | ○ | ○ | ○ |
| 9. | Number of Credits | ○ | ○ | ○ | ○ | ○ |
| 10. | Punctuality of Delivery | ○ | ○ | ○ | ○ | ○ |
| 11. | Overall Quality of Program | ○ | ○ | ○ | ○ | ○ |
| 12. | Helpfulness of Staff | ○ | ○ | ○ | ○ | ○ |
| 13. | Response to Requests | ○ | ○ | ○ | ○ | ○ |

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**Long Island City, NY 11101**

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**Are you likely to use a Hatherleigh program in the future?**

__Yes __ No __ Maybe

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_____

14. What is your primary reason for enrolling in a Hatherleigh program? (Rank the factors, with "1" being your primary reason) ___ Earning Credits ___ Reference Source ___ Ease of Use ___ Affordability ___ Convenience ___ Previous Experience

15. If possible, please briefly describe a way in which your enrollment in this program has improved your practice.

_____

_____

_____

16. How can Hatherleigh's programs better improve patient/client outcomes in your practice?

_____

_____

_____

17. Your favorite lessons in the program were: _____

_____

18. New lesson topics and/or authors who would address your current learning needs: _____

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Comments: _____ _____

# *Frequently Asked Questions*

### *How long does it take to receive my course results and certificates(s)?*

We process quizzes twice a week and results are mailed to you the same day of processing via First Class Mail. If your deadline is near, fax your quiz response form to 1-212-832-1502 for even faster service. You may choose our Express processing options. Express certificates are sent within 48 hours for a $15 fee. Quiz forms requiring Priority or overnight processing must be received by 3 p.m. EST.

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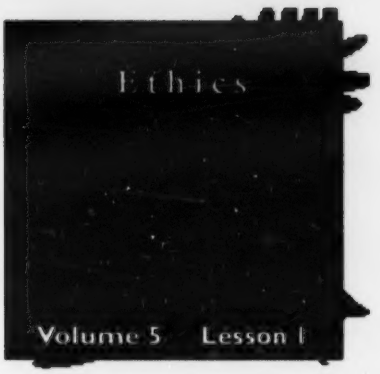


# Ethics in Family Therapy

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## Introduction

From its inception in the 1950s, family counseling has viewed mental health issues from a systemic perspective and sought to answer questions that previous paradigms could not address. As is typical in the realm of mental health work, however, answering one set of questions led to the formulation of many more; one such set of questions regards ethical issues in family counseling. Pioneers in family therapy research and practice endeavored to explain human nature in terms of general systems theory that was replete with terminology such as reciprocal determinism, circular versus linear causality, feedback, and homeostasis (Goldenberg & Goldenberg, 2000). Integral to each of these terms is the idea that the whole of the family system can always be viewed as more than simply a summation of the individual aspects. In other words, families are structured so that each member is influenced by, and influences the family as a whole. In family therapy particular attention is paid to the relationships between family members.

This systemic perspective has served as a way of explaining the influences of interpersonal relations on human growth and development within the family unit. "Problems" are viewed as being primarily between, rather than within, people. This way of perceiving and working with clients opens the door to another set of questions pertaining to the ethical rights of individuals within a family. Since the 1950s, family clinicians have been faced with the inherent dilemma of incorporating ethical principles designed to protect individuals into their work with multiple clients.

## Principle Ethics

Mental health professionals have attempted to create a code of ethics that links ethical concepts and values to ethical decision-making in their work with clients (Remley & Herlihy, 2001). One philosophy that underlies the codes of ethics adhered to by most counselors, including those who work with couples and families, is that of principle ethics, or ethics that have their foundation in moral principles. The following six moral principles are commonly discussed in the professional counseling literature and are the basis of the 1995 American Counseling Association Code of Ethics (American Counseling Association, 1995; Corey, Corey, & Callanan, 1998; Remley & Herlihy, 2001):

1 *Autonomy*—refers to fostering self-determination in clients. Counselors who adhere to this principle respect the rights of clients to choose their own directions and act in accordance with their own belief and value systems

2 *Nonmaleficence*—it is the counselor's duty to do no harm to clients

3 *Beneficence*—it is the counselor's duty to actively promote the mental health and wellness of their clients

4 *Justice*—the counselor is obligated to maintain fairness and equality in their professional relationships. Counselors' actions must be fair to all involved individuals

5 *Fidelity*—it is the counselors responsibility to maintain trust in the counseling relationship. Faithfulness to promises such as confidentiality fall under this principle

6 *Veracity*—it is the counselor's duty to deal honestly with their clients

## Conflicts:

Although these individual principles each represent characteristics of high moral value, at times they may sharply conflict with one another. For example, it is common knowledge that counselors have an ethical and legal duty to protect suicidal clients. Though this duty may respect the principle of beneficence toward clients, it could be argued that obligatory reporting counters the client's right to autonomy. Conflict between ethical principles can be compounded exponentially when working with multiple family members. For example, promoting the autonomy of one member may directly influence the level of veracity used with other members. Fidelity can most certainly be compromised if upholding one member's confidentiality interferes with the rights of another to access information. This is but a sampling of potential conflicts between ethical principles. Green and Hansen (1989) illuminated more specific ethical dilemmas encountered by family counselors who were currently in practice. **The top 16 ethical concerns reported in their study, as cited in Corey and colleagues, (1998) are as follows:**

1 Treating the entire family

2 Having values different from the family's

3 Treating the entire family after one member leaves

4 Professional development activities

5 Imposing counselor values (e.g., feminism)

6 Manipulating the family for therapeutic benefit

7 Payment of services

8 Decisions on marital status

9 Reporting child abuse

10 Supervision of trainees

11 Balancing family and individual needs

12 Consultation with other professionals

13 Informed consent

14 Testifying

15 Working for unethical organizations

16 Sharing research results

**For the sake of organization and brevity we have grouped ethical quandaries faced by marriage and family counselors into the following categories: (a) defining the "client" and client rights, (b) conflicting values and belief systems, and (c) counselor competence.** Within each category we will elucidate specific ethical dilemmas, possible conflicts between legal and ethical proceedings, and current research, if available, regarding each topic. We encourage you to examine your own belief system regarding each issue and carefully consider the consequences for each viable choice that could be made. This lesson will conclude with a model of ethical decision making, a discussion of ways in which ethical dilemmas in family work may be diminished, and questions to be used in the assessment of your own ethics regarding clinical work with families and couples. At the completion of this lesson, coun-

selors will be more fully aware of the complexity of conflicting ethical issues in family work, have a greater understanding of their own belief systems regarding work with families, and be able to formulate ethical decisions based on an ethical decision-making model.

## Defining the "Client" and Client's Rights

In individual counseling there is no question about which individual is the client. However, conducting counseling with multiple clients creates ethical conundrums for counselors in identifying the client and determining client rights. Oftentimes, family members or couples enter counseling because each wants to change the behavior of the other, or they have conflicting interests and goals within their relationship. Also, situations commonly arise where a particular therapeutic intervention would benefit one member of the family at the expense of another (Margolin, 1982). For example, a woman who has been a stay at home wife and mother who wishes to pursue a career outside the home may be encouraged to do so. This has ramifications, however, for other family members who depend on her being in the home.

### Counselor's Role:

Marriage and family counselors must always be aware of the shifting dynamics between family members and ensure that changes benefit the family system or couple. According to Huber (1994), **the counselor can best achieve this goal by being the ally of the system as a unit, rather than that of individual members.** Huber identifies this role of the counselor as a "system advocate" (p. 17) and states that it is **critical that the counselor clearly communicate this role to clients at the start of counseling. Most clients accept the counselor's position as a condition of counseling**; however, there may be instances in which individuals will attempt to gain the counselor's alliance, and situations where the counselor will need to advocate for the rights of an individual (e.g., in cases of spousal abuse). **Thus, the difficulty for counselor's lies in balancing the various goals of the individuals in the couple or family, as well as their own goals.** Margolin (1982) illuminates this position:

> *Attempting to balance one's counseling responsibilities toward individual family members and toward the family as a whole involves intricate judgments. Since neither of these responsibilities cancels out the importance of the other, the family counselor cannot afford blind pursuit of either extreme, that is, always doing what is in each individual's best interest or always maintaining the stance as family advocate. (p.790).*

In multiple client situations where there is the possibility of conflict in a counselor's roles, the counselor should clarify, change, or remove himself or herself from these roles as deemed appropriate to the situation. Consider this example: A counselor saw a husband and wife for couple counseling. Several years after the couple ends counseling the couple divorces and the wife requests that the counselor testify on her behalf in a custody hearing. The best ethical course for the counselor in this case would be to refer the wife to another counselor because the counselor's "client" had been the couple, not just the wife.

### Confidentiality:

Central to the counseling relationship, and at the core of many ethical dilemmas, is the ethical issue of confidentiality. Confidentiality allows for trust, privacy, and security to develop in the relationship between counselor and client; it protects clients from the social stigma often associated with counseling and is the bulwark of both client's rights and the counseling profession (Denkowski & Denkowski, 1982). Confidentiality is based on privacy; more specifically, it refers to the obligation of the counselor not to disclose any information about a client that was obtained as part of the professional relationship without the client's permission. As most mental health professionals know, **the limits of confidentiality include cases in which (a) they suspect child or elder abuse, (b) they believe that the client(s) is at-risk for harming himself/herself or another person, and (c) when records are subpoenaed by the courts.**

Determining which individual is the client can create issues of confidentiality. For example, one family member may refuse to participate in counseling, or the goals of spouses may be in conflict; the wife may want to

work on the marriage while the husband wants a divorce. To provide clear expectations, ethical standards (e.g., American Psychological Association, 1992) require counselors to **clarify at the beginning of counseling (1) which persons are clients and (2) the relationship the counselor will have with each person.**

**The theoretical orientation of the counselor may ultimately dictate who the client is and how the counselor approaches counseling.** For example, a Bowenian-based counselor may want to work primarily with the couple dyad to effect change across the family system; someone with a structural orientation may wish for all the subsystems within the family to be present in the therapy room. Counselors using a systemic approach may work with the family as the client and will not meet with members individually or keep information disclosed by one family member secret from the other members. However, counselors with other philosophies may meet individually with family members and may agree to keep secrets from the other family members. Again, these issues must be determined and clearly explained at the beginning of counseling.

There are several terms related to confidentiality which should not be confused with it; ***privacy*** **refers to an individual's right to decide how much personal information to share with others, and** ***privileged communication*** **is a legal term that prevents confidential information from being revealed in court without a client's permission.** In most circumstances, the privilege belongs to the client and protects the client, not the counselor (Corey, Corey & Callanan, 1998); however, when a client is a minor or is legally incompetent, the parent or legal guardian holds the privilege.

## Informing Partners of HIV Status:

A recent controversy affecting family counselors has to do with whether to warn sexual partners of HIV-positive clients. Schlossberger & Hecker (1996) note that the Tarasoff case established that counselors are **required to "warn potential victims of illegal dangers posed by clients, but does not require counselors to warn potential victims of (other) dangers posed by their client's legally permissible actions"** (p. 27). These authors conclude that "unless state law (criminal or tort) directly or indirectly generally requires seropositive clients to inform their partners, counselors have no legal duty to warn" (p.33). However, in the case of family or couple counseling, when the uninformed sexual partner is also a client (e.g., the husband of HIV-positive wife), counselors face a challenging ethical dilemma regarding their loyalty to their clients. **The counselor should attempt interventions geared toward changing a client's behavior and prompting the client to warn partners** (Schlossberger & Hecker, 1996). **Counselors should delineate a general policy of disclosure for when the interests of their clients are in conflict.** However, Harding, Gray, & Neal (1993) recommend that disclosure of HIV status should be a last resort after other options have been exhausted, especially in cases where the noninfected partner is not a client. In other words, it is suggested that the infected partner make the disclosure, not the counselor, whenever possible. This alleviates the counselor's responsibility without breaking trust, and empowers the infected one to speak for him/herself.

## Minors' Rights:

Respect of minors' rights is a complicated issue in counseling. **Children have a right to privacy, but this right is not protected by law**. Also, children are not always developmentally capable of making decisions that affect their welfare. When treating children, the counselor must balance the demands of parents, respect for the child's privacy, and confidentiality and legal limitations. **Counselors are encouraged to examine laws and rights pertaining to minors in the state in which they practice as these tend to vary from state to state. Counselors should provide informed consent in the beginning of the counseling relationship that includes legal and ethical obligations.**

## Domestic Violence:

This is a challenging situation; a number of factors come into play in determining who is viewed as the client, how confidentiality is managed, and the ethical responsibilities of the counselor. The counselor's theoretical orientation will certainly influence the goals for counseling. **Additionally, family members may have very different views about the violence**. Willbach (1989) states that if the family has not acknowledged the violence, or if family members do not agree about its significance, traditional family counselors may

choose to not work directly to stop the violence because they may view it as "a sign of underlying and more primary systemic dysfunction" (Bograd, 1984, p. 560). **However, when a counselor is aware of family violence, "his or her overt goal should be its complete cessation"** (Willbach, 1989, p. 44). **Neutrality techniques should not be utilized; counselors should use their ethical judgment to "identify individual responsibility for the violence, and unless the violent person is initially able to contract for nonviolence, a conjoint or family modality should not be used"** (Willbach, 1989, p.44). We believe that it is imperative for the violent individual to face his or her responsibility, and that "breaking down" this denial is similar to what must happen for individuals engaging in other types of abuse such as child or elder abuse, sexual abuse, and substance abuse.

**It is the duty of counselors to intervene if clients report they are a danger to themselves or others, or if a child, elder person, or developmentally disabled person is being injured; however, there is no direct mention of reporting domestic violence in the codes of ethics followed by counselors.** It is, therefore, difficult to determine ethical courses of action in these situations and much depends on the individual situation. **If a person is trying to leave a violent situation, her/his safety is the priority. Counselors should not insist that an abused person leave the abusing partner unless there is a safety plan in place whereby the one leaving has a safe place to go without threat of further harm.** Often, the point of departure is one of grave threat to the victim. Counselors should work with their clients to develop safety plans and contact the authorities regarding restraining orders and other protective measures.

### Child Abuse:

Reporting child abuse also can be a difficult duty for family counselors. **Counselors are required by law to report child abuse.** However, disclosing child abuse, especially when the abuse is incest, **significantly affects the family system and is likely to have a permanent impact on the family structure** (Alexander, 1992; Gavey et al. 1990). It is a challenge for counselors to balance the mandate to report, which supports the moral principle of nonmaleficence, without betraying client's rights, specifically the principles of autonomy and fidelity, especially when the entire family system is the client (Haverkamp & Daniluk, 1993). Viewed in another manner, **reporting child abuse clearly communicates to the family the counselor's unwillingness to collude in ongoing abuse and keeping the "family secret"** (Courtois, 1988). **Counselors should clarify the limitations of confidentiality with their clients at the beginning of the relationship to support fidelity.** In many states, counselors and other helping professionals are legally mandated to report even suspicions of child abuse to local child welfare authorities. They can do so anonymously if they choose. Child welfare workers and, in some cases, local police officers are typically responsible for investigating and determining the presence and/or extent of abuse. Counselors should become familiar with reporting policies in their state of practice.

### Decision-Making in Abusive Relationships:

Ultimately, it is the responsibility of the family members to decide whether or not to keep relationships intact. The counselor may offer an opinion, but it should be stated as such, not the "correct" answer. Counselors may report child abuse/neglect, but will not make the final decisions regarding whether or not children stay in the home. Family counselors are urged not to push their values, but rather explore and try to understand the phenomenological world of their clients. **Counselors can point out options and consequences, but the goal is to empower clients to make healthy choices for themselves. If a counselor feels she or he cannot work with particular familial dynamics, a referral should be made.**

## Values and Belief Systems in Working with Families

Counselors have values and belief systems, as do clients, supervisees, students, and other providers and consumers of mental health services. Counselors' biases about spirituality and religion, gender roles, abortion, sexual orientation, family structure and family roles, child discipline, language, ethnicity, race, and socioeconomic status may make it difficult to treat clients without consciously or unconsciously imposing those values. **Ethics codes for all mental health professions**

**acknowledge that it is essential to respect clients' values and beliefs and the right of clients to determine the course of their lives in a manner consistent with those values.** Counselors should not impose their own values, belief systems, or agendas on clients but should respect clients' autonomy, dignity, and worth (American Psychological Association, 1992).

Bloch and Harari (1996) advocate for recognizing the interconnectedness between values and counseling intervention with the family. Aponte (1985) summarizes:

> *For the counselor, values are an essential component in defining and assessing a problem, determining goals, and selecting counseling strategy. Counselors do not have a choice about whether they need to deal with values in counseling, only how well. (p. 330).*

Odell and Stewart (1993) remind us that counselors should create and affirm a **counseling environment where client's ability to disagree with counselors is valued and fostered;** this point is emphasized to encourage clients to maintain their own values rather than adopt those of the counselor. In addition, Bloch and Harari (1996) suggest that counselors recognize that although some values are consistent within a family, families also struggle with conflicts regarding individual values that are not upheld by the family system, and that both family and individual values are central to the family's structure. **To work effectively with families and others, counselors will need to examine their own values in relation to those of their clients** (Odell & Stewart, 1993).

Bloch and Harari (1996) provide the following guidelines for counselors to consider when negotiating a family's values and their own:

- **Counselors should not commandeer the role of the family "expert" in how to understand and solve family problems.**
- **Counselors should share advice as appropriate, but the primary role is to encourage family members toward their own explorations and conclusions, both as individuals and as a system.**
- **It is critical that counselors monitor their own values and do not impose those values on clients. Counselors should be comfortable encouraging the family to reevaluate certain of their values to promote "functional change" (p. 280).**

Counselors should work with family members to recognize incongruities in their values when these values are a source of conflict. An example of such a conflict is parents wanting their adolescent child to be less autonomous.

However, counselors will find many ethical complexities, especially when their values conflict with client's beliefs. Using a collaborative approach with clients to examine issues about belief systems enhances the trust and safety of the counseling relationship (Haug, 1998). Collaboration may extend to **including others from a client's religious or ethnic community**, such as a Native American healer in the counseling process. Also, **adapting clients' use of language about their beliefs and values conveys the counselor's understanding and lack of prejudice. For counselors who are part of a religious community, counseling with members of that community may risk role confusion, the clouding of social and professional boundaries, and potential harm to the client** (Haug & Alexander, 1992). When a counselor's values clash with those of the clients and the counselor does not believe he or she can provide appropriate services, the clients welfare may be best served through referrals to other appropriate mental health professionals, clergy, etc.

## Cultural Identity:

A counselor's understanding of the significance and meaning of the cultural identity of clients is critical for understanding the client's value system. **Values, roles, and conflicts regarding cultural identity are often a struggle for clients from minority ethnic groups and cultures.** African Americans are especially vulnerable to an experience of confusion and conflict in the American culture (Pinderhughes, 1989). Values and behavioral norms of the clients' own culture often diverge from the North American mainstream; the latter often excludes members of minority ethnic groups from total

participation, connection, and identification with it. Further, **U.S. culture accentuates individuality, freedom of choice, and self-determinism while many other cultures emphasize family relationships, group cohesion, interdependence, and self-restraint.** Accurate assessment, treatment, and cultivation of a trusting and engaging counseling relationship depend on understanding the client's value system.

In order to ensure that the counselor's values do not overpower those of the client, counselors must first assess and become aware of their own belief and value systems. **Should a client's value system clash with that of the counselor in a way that impedes the therapeutic relationship, it is the counselor's obligation to discuss this with the client in a very non-judgmental manner. The client and counselor can then decide jointly if a referral to another mental health professional is the best course of action.**

## Counselor Competence

Clinicians and counselors-in-training who choose to specialize in marriage and family counseling are faced with unique challenges. They are, therefore, obligated to obtain and maintain competency in working with the intricacies of family systems. **Personal growth experiences (such as participating in individual and/or group therapy), continuing education, and supervision/consultation are ways of maximizing competency for family counselors.**

Personalization issues, or countertransference phenomena, are typical to some degree in most counseling relationships. **Family work, in particular, may provoke reactions in the counselor related to his or her own family of origin experiences.** Family counselors are urged to continually further their own self-awareness regarding familial influences. For instance, completing a three-generation genogram (Bowen, 1978) of one's family of origin, paying particular attention to the cross-generational patterns of relating, is an excellent way of enhancing awareness in relation to one's own family.

Counselors should also be aware of their biases/values regarding gender roles, sexism, and power within families. Some feminists have argued that a strong systems approach, which puts the family as a whole before its individual members, may disempower members who currently have a lesser voice. Taking only the perspective of reciprocal determinism may foster ignorance of unhealthy power imbalances that are at play in some families. **Family counselors are cautioned to be aware of their own perspectives regarding power distribution and ways in which their actions empower or disempower family members.** Walrond-Skinner (1987) has advocated for the counseling ideal of a mutual and nonsexist participative culture. In this model, all family members, regardless of gender or age are enlisted to further their own human potential through caring interactions with one another. Relational approaches such as this focus attention on "mutual commitments" to one another (Doherty, 1995), and balancing close, caring relations with others and maintaining a clear, solid sense of self (Bardill, 1997). Family counselors have the dual tasks of helping individuals as well as families flourish. Maddock, (1993) noted that to use relational approaches ethically, one must consider the following three dimensions of interaction:

- **The relation of a system as it is to the system it is becoming**
- **The relation of one system to another as useful, i.e., the "good for" or "bad-for" qualities of each system in relation to the other—in other words, are the "good things" that will happen in one system "good" or "bad" for other systems.**
- **The relationship of "A" and "B" to each other—that is, what is the comparison between each system's movement toward becoming something different and how are the movements in each system related? (p.119)**

Counselors should always consider how changes in one aspect of the system or family are influencing other changes, and how these changes influence individual members of the system.

Though there continues to be debate regarding whether marriage and family counseling is a separate discipline or a specialty within counseling (Remley & Herlihy, 2001), family counselors do require special training and supervision to develop competency. To

work ethically with families and couples, counselors should seek training from either a program specializing in the training of marriage and family counselors or an accredited counseling program that includes a specialization in marriage and family counseling. Both the American Association of Marriage and Family Counselors (AAMFT) and the International Association of Marriage and Family Counseling (IAMFC), which is a division of the American Counseling Association, have ethical codes to which members must adhere. Included in the codes of ethics are mandates that counselors do not practice outside the boundaries of their competence. Counselors who do so may face both ethical and legal sanctions.

The purpose of the AAMFT Code of Ethics and Ethics Committee (as well as comparable codes and committees of the American Psychological Association and American Counseling Association, etc.) is to protect consumers of counseling and mental health services from unethical practices by these organizations' members. Although these organizations respond to complaints of unethical behavior, their ethics committees exist primarily for consultation and educational purposes for members. What happens if there is a complaint by a client or other AAMFT member about a counselor's conduct? **Huber (1994) presents a summary by Engleberg (1985) of the processing of ethical complaints:**

> **Cases consist of complaints brought against AAMFT members for violating the AAMFT code of Ethical Principles. Complaints may be brought against an AAMFT member by another AAMFT member, by nonmember counselors, by clients, by members of the public, and by the ethics committee itself (p. 88).**
>
> **If the charged professional is determined to be an AAMFT member and the complaint is determined to state a claim covered under the Ethics Code, the person filing the complaint (e.g., client) is sent a waiver of the client–counselor privilege. When the waiver is signed, a letter is written to the charged member (e.g., counselor) requesting a response. The Ethics Committee may decide the case via written communication with the charged member. In some cases the charged member may have the opportunity to appear before "an investigating subcommittee." Cases are often disposed of through a process of agreement called "settlement by mutual consent." If settlement by mutual consent is not possible, the Ethics Committee can recommend to the AAMFT Judicial Council that final action be taken against a member. Any proposed settlement or final action recommended by the Ethics Committee can include a requirement that the charged member seek counseling or obtain supervision. The Ethics Committee is also authorized to propose revocation of a member's approved supervisor status and, in most serious cases, termination of AAMFT membership. Charged members who wish to appeal Ethics Committee recommendations that final action be taken may do so to the independent Judicial Council. At that point, the Ethics Committee is, in effect, prosecuting the complaint and the Judicial Council makes the final ruling on the matter.**

It is our belief that counselors who wish to work in family and couple therapy should become members of professional organizations that promote ethical work with families and couples, and adhere to the standards and ethics of such organizations. In addition to training and professional memberships, even **veteran counselors should seek regular supervision and consultation regarding the complexities of family work; it is easy to become involved with families to the point where objectivity is lost. Though effective family counselors may enter the family system, none should be consumed by it.**

## Analysis of Ethical Dilemmas

Despite rigorous attention to ethical practices, provision of informed consent, and ongoing supervision/consultation, marriage and family counselors will find themselves in positions that necessitate careful decision making regarding ethical questions. Woody (1990) proposed using five decision bases for a comprehensive analysis of ethical dilemmas. Included in these bases are:

- **Theories of ethics**
- **Professional codes of ethics**
- **Professional theoretical premises**
- **The sociological context**
- **Personal/professional identity**

Counselors are urged to be aware of, and able to integrate information from each of these bases of information. For simplification, **the following decision-making model in Table 1 reflects adaptations of the work and suggestions of various editors and researchers** (American School Counseling Association, 1996; Bivins, 2000; Corey, Corey, & Callanan, 1998; Huber, 1994; Remley & Herlihy, 2001).

Again, values are inherent to the ethical decision making process. To enhance decisions related to defining the client and client's rights, differing values and belief systems, and counselor competence, counselors may find answering the following questions to be useful. There are no "right" or "wrong" answers. Answers may change over time and with counselor development; counselors are urged to reexamine these questions periodically and reevaluate their answers and the context in which they were answered.

*1* **What factors do you consider when determining whom to work with in family counseling?**

*2* **To what family member, if any, would you feel most responsible?**

**Table 1**

**ETHICAL DECISION-MAKING MODEL FOR MARRIAGE AND FAMILY COUNSELORS**

1. Determine specifically what constitutes the ethical decision/dilemma.
   - A. Is it a moral or legal issue?
   - B. Are there conflicts between your code of ethics and legal mandates?
   - C. What value conflicts are involved?
2. List all possible options you may use.
3. Determine who is involved—include all parties who may be affected by your decision.
   - A. To whom do you owe the most allegiance?
   - B. Does this allegiance outweigh the potential harm to other stakeholders?
4. Examine the moral principles involved. In what ways are autonomy, nonmaleficence, beneficence, justice, fidelity, and veracity being promoted or ignored for each involved party?
5. Examine the relationships involved; these include relationships between family members, relationships between the family and other systems, and the relationship(s) between the counselor and family members
   - A. What relationships would be affected by each option?
   - B. In what ways does each decision optimize or damage healthy relationships?
6. Based on ethical, moral, and legal considerations as well as the judgment of the counselor, weigh whether individual rights or interpersonal relationships are of more importance in this case.
7. What are the best- and worst-case scenarios for each option? Can you personally and professionally live with the worst-case scenario?
8. Consult!
9. When information has been collected, it is ultimately the counselor's responsibility to make a decision and document the decision making process.
10. Implement your decision.

3 **Under what circumstances, if any, would you consider not reporting child abuse? Suicidal ideation? Domestic violence?**

4 **In what situations would you consider keeping "secrets" of one or more family members from others?**

5 **What are your values regarding:**

- **Keeping families together**
- **Divorce**
- **Infidelity—reported/unreported**
- **Ability of "abusers" to change**
- **Cultural/religious/political affiliations**
- **Gender roles/sexual orientation**

6 **How should power be distributed within a family?**

## Conclusions

It is apparent that although family counseling provides rich opportunities for exploration and growth, and answers questions that individual therapies cannot, the complexity of a systems approach also generates many possible ethical dilemmas. Simply "defining the client" can become somewhat of an ethical quagmire. The value and belief systems of the family, its members, and the counselor(s) interact to create a macrosystem with possible conflicts between the various subsystems. When examined from such a broad perspective, the ethics of family counseling can seem overwhelming. In reality, ethical decisions are made one by one. Many decisions can be made in collaboration with clients, and many can be avoided by providing proper informed consent.

### Informed Consent Document:

Marriage and family counselors should consider providing clients with an informed consent document that includes the following:

- **The theoretical orientation used by the counselor (i.e., a Bowenian systems approach that includes examining generational influences)**
- **Possible impact of engaging in systems-oriented counseling, (i.e., some members may not initially like or benefit from changes that occur, but all will be affected)**
- **The counselor's "style" of working (i.e., directive or nondirective)**
- **Expectations for the participation of family members in counseling—this includes conjointly deciding which family members will participate in counseling, and what guidelines they will follow, such as not keeping damaging secrets from one another.**
- **Policies regarding the confidentiality of individual members (i.e., do adolescent family members have the right to share information with the counselor that will be kept private from the parents?)**
- **Legal and ethical exceptions to confidentiality (i.e., reporting abuse)**

We contend that the values of family counselors always are influential, both within and outside the counseling session. Thus, it is arguable that a discussion between the counselor and client family regarding values that are important to all may be beneficial as well as prevent later misunderstandings. For example, if a counselor values the importance of a family structure in which parents hold more authority than children, this may be discussed in an initial session. Another example is that of the counselor who believes that infidelity should not be a secret between members of an intimate couple. The counselor may want to disclose this value up front when working with couples to dispel the notion that one member of the couple will be allowed to use the counselor as a confidante regarding issues that pertain to the other member. Frank discussion of these and other potential ethical dilemmas circumvent the necessity of making a decision that may hurt a client who has already shared information.

When ethical decisions develop a severe or legal nature, counselors should consult with other colleagues or experts. **Consultation not only eases the isolation of the counselor's decision making process, but pro-**

**vides additional protection for the counselor should the decision be questioned in court or other legal proceedings.** Following the systemic perspective from which they practice, counselors should use their own surrounding systems to buffer the occasional enormity of conflicting ethical principles.

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## Questions Based On This Lesson

*To earn CE credits, answer the following questions on your quiz response form.*

1. **Which one of the following principles is supported when the counselor clarifies the limits of confidentiality and, thus, *does not* break his promise of confidentiality in a difficult situation such as reporting child sexual abuse?**

   A. Autonomy

   B. Empathy

   C. Justice

   D. Fidelity

2. **What ultimately dictates who is identified as the client in family counseling?**

   A. State law

   B. The wishes of the custodial parent

   C. The counselor's theoretical orientation

   D. Federal mandates

3. **To minimize conflicts related to confidentiality in family counseling, therapists should:**

   A. Assure all family members that nothing they disclose will ever be repeated outside the session.

   B. Deal with confidentiality issues as they arise.

   C. Explain the limits to confidentiality in an informed consent document prior to counseling.

   D. Let clients choose what is or is not divulged outside of counseling.

4. **If a counselor's values clash strongly with those of a family with which they are working, and they feel that this disparity will make it difficult to reach the counseling goals, than the counselor should:**

   A. Attempt to change the values of the family—after all, the counselor is the expert on human behavior.

   B. Discuss this nonjudgmentally with the family and ask them to consider a referral to another counselor.

   C. Hide her/his values and hope they don't interrupt the counseling process.

   D. Change her/his value system to that of the family.

# Ethical and Legal Dimensions of Counseling in Schools

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## Introduction

There has been a dramatic increase in the number of problems that affect adolescents' mental health over the last few years. High rates of substance abuse, teen pregnancy, suicide, and youth-on-youth violence, to name a few of these issues, have served to underscore the importance of addressing the psychosocial and emotional needs of young people in the most efficient and timely manner. Given that many of these issues accompany students into school buildings, and most young people attend school, increased attention is being focused on schools as settings of choice for identification and treatment of mental health issues that disrupt the lives of students and families. However, this can be difficult for a counselor in the school, who has the unique experience of working in a setting where two distinct professions merge. More specifically, practices that reflect the norms and values of the counseling profession often differ from those of educators. This, combined with a host of state and federal regulations governing school policies, creates a context with unique challenges for a professional counselor.

This lesson will examine ethical and legal dimensions associated with counseling in schools. While many counselors in schools have the title of "school counselor," it is recognized that counseling functions are performed by a variety of professionals, including licensed mental health counselors, psychologists, and social workers. Because of this, the information presented in this lesson will assume a wide range of experience and professional preparation, and will focus on contextual aspects of the school environment that directly influence the practice of ethical counseling in schools.

At the end of this lesson, the reader should be able to do the following:

- **Recognize and discuss elements of the school context that impact counseling in schools.**
- **Identify the general characteristics of codes of ethics and the professional codes of ethics relevant to counseling in schools.**

- Recognize and discuss major legislation that influence how school counseling is done.
- Discuss confidentiality as it pertains to counseling in the school context and understand the balance between parents' rights and minors' rights as they relate to privacy, student records, informed consent, and permission to see a counselor in the school.
- Recognize special ethical concerns related to group counseling, counseling diverse student groups, counseling students affected by HIV, and students who are considering abortion.
- Be familiar with, and list the steps of an ethical decision-making model.

## The School Context

### Schools as Organizations:

School systems are highly structured, bureaucratic organizations. Because the nature of a bureaucracy is to insure conformity and efficiency in pursuit of a common goal, a number of rules and regulations are created that are enforced through a hierarchy of power and authority. In most bureaucracies, the hierarchy of power is vertical; this hierarchy is represented by systems of superordination and subordination that oversee compliance with organizational expectations (Hoy & Miskel, 1996). In a school system, the hierarchy of power generally flows from the Superintendent at the pinnacle, to the Principle, and down to teachers, custodial, and lunchroom workers towards the bottom of the scheme. The main responsibility for enforcing bureaucratic expectations lies where there is most authority, while those who are responsible for the delivery of services that fulfill the institutional mission have the least amount of authority. This does not mean, however, that they are completely powerless in the organization. To illustrate this, consider a math teacher in a high school. She, (and her colleagues, if it is large school), is the only one in the organization with the expertise to teach principles of calculus. Because the organization exists for the education of its students and depends on the proficiency of teachers to do it, there is a measure of power that accompanies the math teacher's expertise; she is granted significant autonomy in choosing when and how she will teach. She is guided in her efforts by her professional knowledge, which is supported and validated by others in her field. Furthermore, she makes decisions based on the best interests of her students.

This begins to delineate a basic conflict that can occur in this structure: the conflict between professional values and bureaucratic expectations (Hoy & Miskel, 1996). **Whereas professionals make decisions based on the best interests of their client,** (backed by training and experience within a domain of knowledge, and guided by professional literature and codes of ethics) **bureaucrats make decisions based on the best interests of the organization. The result is that a counselor may be caught between a student's needs and the needs of the system.** For example, there are often times when a counselor knows a certain teacher's personality will clash with a student. **However, counselors are prevented by administration from facilitating a schedule change, even though it might provide a better experience for the student.** ("What would happen if we let every student choose his or her own teachers?") Fortunately, there is often alignment between student needs, professional autonomy, and system needs, but it is not uncommon to witness conflicts. The school counselor is always hanging in the balance between professional autonomy and bureaucratic control.

### Priorities:

Whereas a counselor working in a traditional setting, such as a mental health center or in private practice, is in direct alliance with the institutional mission (i.e., treatment of mental health conditions), school counselors often find that their services are considered ancillary (Baker, 2000). This does not mean that counseling services are underappreciated, or that their contribution is less significant; rather, **it indicates a context in which services are justified by their ability to meet an educational end rather than a therapeutic end.**

For the most part this is not problematic because educational problems often stem from personal, psychosocial, and emotional problems. There are, however, times when successful counseling might produce results that aren't consistent with educational goals of a system

(Schulte & Cochrane, 1995). For example, a student who decides to drop out of school after having spent several hours with the counselor may inspire conflicting thoughts and feelings for that counselor. On one hand, the counselor knows that schools can be very oppressive places for students and not all students are best served in the conventional system. Believing this, he/she might even facilitate a smooth transition from high school for the student. On the other hand, the counselor might be very aware of how this student's decision could be perceived as failure to produce a favorable academic end. If too many students decide to drop out, the counselor might be asked to justify a position that is not contributing to school success.

In some cases, the primacy of the educational mission is expressed in professional relationships among faculty in the school. **The belief that one job is more important than another by virtue of how closely it relates to the academic mission can lead to subtle attitudes of superiority in the professional ranks. For example, some teachers will refuse to let students out of class to see a counselor.** While this doesn't necessarily represent an ethical situation, it does illustrate a contextual reality that might have an impact on a counselor's ability to work with students and faculty. In this case, the counselor must decide whether or not to confront an uncooperative teacher. If she or he chooses confrontation, she/he must consider how their actions will affect their reputation with the faculty (e.g., being seen as an outsider or troublemaker). Alternatively, if they choose not to see the student in order to maintain a cooperative appearance, are they abdicating their responsibility to the student? Both choices have potentially powerful consequences.

### Open vs. Closed Communication Systems:

Welfel (1998) discusses the "clash of cultures" that occurs when a counselor who is trained to carefully guard clients' personal information encounters expectations for freely shared information by faculty who depend on it to teach effectively. For example, a 7th-grade science teacher would readily inform colleagues that a certain student's parents were soon to be divorced and that the student was having a bad day and had to be sent out of class because she was crying. From the point of view of teachers or administrators, this kind of information is useful because it allows the system to be sensitive to circumstances that will affect the student's learning. It also serves another purpose among faculty; the **willingness to share information freely sends a signal to teachers and administrators that one is a "team player." The pressure to conform to the expectations of a school system are substantial** (Schulte & Cochrane, 1995). Welfel (1998) states:

> *Teachers and administrators expect them counselors) to communicate openly about students and see themselves as equals, with just as much concern for the best interests of students as counselors have. When counselors are not forthcoming about matters disclosed by students, other educators can be confused and even offended. (p.336).*

Moreover, the decision carries with it the power of group acceptance or exclusion. Thus, counselors find themselves in a place where they are required to balance their own need for group affiliation, respect, and acceptance (as well as referrals from other personnel) with their client's need for privacy (Welfel, 1998).

## Ethics for Counselors in Schools

The school setting adds complexity to the already difficult job of counseling children and adolescents. Counselors are commonly required to balance competing needs and challenge their ability to make decisions that simultaneously benefit all parties involved. Several codes of ethics have been developed specifically to aid counselors with these types of decisions. Before examining several codes, I would like to make some observations about ethics codes in general.

### The General Nature of the Code of Ethics:

It is important to note that while codes of ethics are published as formal documents, they are not hard and fast rules that govern behavior. Rather, they act as **guidelines for the professional who often must interpret the codes within a certain context and apply them to a specific problem.**

Second, ethical codes are always based on what is considered to be generally acceptable behavior (what is good, just, right, or moral) during a particular time in history. Therefore, **they are dynamic principles that evolve over time.**

Third, there are several basic moral elements upon which codes of ethics are built that can be traced through time and evolution. The principles of ***beneficence*** (first, do good), ***nonmaleficence*** (do no harm), ***justice*** (be fair), ***fidelity*** (be faithful, keep your promises), and ***human autonomy*** (respecting human dignity and self-determination) are easily discernable, and serve as the basis for all ethical decisions.

Fourth, **how a person reads and interprets ethical codes is always influenced by his or her own personal value and belief systems.** For this reason, it is good practice to consult with colleagues to achieve as much clarity and objectivity as possible.

Finally, codes of ethics are not legal documents. Although they are influenced by, and sometimes run parallel to elements of law, **violations of ethical codes do not necessarily carry legal consequences**. The issue of sanction is left to the governing body of the professional association to which one belongs, or to the licensing board of each particular state. However, if a matter is referred to the courts, failure to demonstrate adherence to ethical guidelines would most likely result in a ruling of malpractice or negligence.

## Codes Relevant to the School Context

Muro and Kottman (1995) have suggested that three codes in particular are relevant to the school setting.

### *Code of Ethics and Standard Practice*

The American Counseling Association published a revised version of its Code of Ethics and Standard Practice (ACA, 1995). It provides the foundations for ethical counseling practice in any context, and serves as the umbrella for other codes. Sections that address the (1) counseling relationship, (2) confidentiality, (3) professional responsibilities, (4) relationships with other professionals, (5) evaluation, assessment and interpretation, (6) teaching, training and supervision, (7) research and publication and (8) resolving ethical issues provide the foundation for ethical decisions across a broad context.

### *Ethical Standards for School Counselors*

**The American School Counselor Association's Ethical Standards for School Counselors** (ASCA, 1992) **reflects many of the same standards found in the ACA's code, but also accounts for the unique setting and specialized training school counselors receive.** Sections that address responsibility to students, parents, colleagues and professional associates, the school and community, oneself and the counseling profession are especially helpful in understanding professional responsibility to the diverse constituency of the school and surrounding community. Whereas specific guidelines for dealing with an activity that is disruptive to the school mission are not found in the ACA code, this information is addressed in the ASCA code. For example, Section D.1 states that a counselor is responsible to report to appropriate officials when conditions exist that will disrupt the school mission, personnel, or property. This does not necessarily mean that a counselor will break confidentiality to do so; it is possible that conditions can be reported without revealing names. However, if one is contemplating breaching confidentiality, the code also suggests that one seek consultation from another professional before doing so. (Section A. 10).

### *Ethical Guidelines for Group Counselors*

The third relevant code of ethics is Ethical Guidelines for Group Counselors, published by the Association for Specialists in Group Work (ASGW, 1989). **A counselor will find specific guidelines pertaining to the group leader's responsibility to provide informed consent, delivery of group counseling services, and safeguarding ethical practice in group work.** The saliency of this code lies in its discussion of the limita-

**Table 1**
**URLS FOR PROFESSIONAL ORGANIZATIONS**

**American Counseling Association**
www.counseling.org

**American School Counselor's Association**
www.schoolcounselor.org

**Association for Specialists in Group Work**
http://asgw.educ.kent.edu

tions of confidentiality in group settings. It also provides guidelines for group screening, and informed consent that is not found in the other codes.

Together, these codes provide the basis for sound judgement and are excellent resources when difficult issues arise. The reader is strongly encouraged to read and understand each code as it relates to the school setting. Copies of each can be obtained by visiting the web site of the professional organizations, or by writing and requesting copies to be sent. The URL's are listed in Table 1.

## Federal Legislation Affecting Schools

Oftentimes, when a student's rights or privileges are not being respected in a school setting and the counselor will find themselves in the position of acting as a student advocate. For this reason, it is incumbent on the counselor to be aware of laws that exist for the protection of students and families. Section A.5 in the ASCA (1992) code of ethics states, "The school counselor is responsible for keeping abreast of laws relating to students and strives to ensure that the rights of students are adequately provided for and protected." Accordingly, the next section of this lesson will briefly address several of the major legislative initiatives that have a potential impact on how counseling is delivered in schools. This information is not meant to be exhaustive, but rather to provide the reader with a general sense of the purpose of each of the initiatives.

### The Family Educational Rights and Privacy Act of 1974:

The Family Educational Rights and Privacy Act (FERPA; PL93-380), which is also known as the Buckley Amendment (Muro and Kottman 1995; Baker, 2000; Fischer & Sorenson, 1996), was passed in 1974 in an effort to safeguard student records and protect them from access by anyone not directly involved with the student's education. **It requires written permission from the student or from the parents of a student who is a minor. It also gives parents the right to be informed and give consent when their student undergoes assessment, or when any school-based activity that could change a student's behavior or values is occurring. In effect, it denies federal funding to institutions that do not abide by its guidelines, and is therefore taken very seriously by school administrations.**

Although the law itself is too lengthy to cover in detail here, there are several points worth mentioning. First, educational records are described as any record or material directly related to a student that are maintained by the school or an agent of the school (Baker, 2000). **Parents and students have the right to gain access to these records upon request, and must provide written permission for anyone else who is not directly related to the student's education to access them. Private notes or confidential notes written by a counselor are considered exempt from this provision, as long as they have not been shown to anyone else** (Baker, 2000; Birdsall & Hubert, 2000).

### Individuals with Disabilities Education Act:

Many students that a counselor might interact with in a school setting have been given special accommodations under The Individuals with Disabilities Education Act (IDEA; PL94-142). This act **guarantees equal and appropriate public education to any student who is considered disabled in a way that impairs their ability to learn** (Muro and Kottman 1995; Baker, 2000; Fischer & Sorenson, 1996). Perhaps the most salient feature of the law as it relates to a counselor's role is the Individual Education Plan (IEP). **The IEP is a formal document that contains provisions for special education and related services as they are required to accommodate a student's disability. Counseling falls under the "related services" section, and is often included in cases where counseling has been determined to be beneficial to the student's education.** The decision to include counseling is usually made in concert with a team of educators, including the student's teachers and administrators, a school psychologist, and the student's parents. Parents or legal guardians of the student are ultimately responsible for approving an IEP unless the student is legally considered an adult.

### Section 504 of the American with Disabilities Act:

**This federal provision protects all disabled people, including students, from discrimination based on**

**their disability.** While IDEA generally refers to accommodations for those who are impaired and require special education and related services, Section 504 of the American with Disabilities Act (ADA) **applies to students who are health impaired, but not in need of special education** (Fischer & Sorenson, 1996). It requires public schools to provide accommodations that will allow any student who is considered impaired to be afforded appropriate educational services. The act defines a person with a disability as anyone who:

- **Has a mental or physical impairment which substantially limits one or more major life activities (e.g., major life activities include caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working)**
- **Has a record of such impairment**
- **Is regarded as having such an impairment**

Along with obvious physical impairments, **section 504 has been applied to include students infected with HIV/AIDS, students with Attention-Deficit Hyperactivity Disorder, and, in some cases, students recovering from addiction.**

### Title IX of the Education Amendments of 1972:

This act **protects all students from discrimination on the basis of sex/gender and denies federal funding to any institution that does not offer equal access to school programs for girls and boys** (Baker, 2000; Fischer & Sorenson, 1996). Its initial significance stemmed from the effect it had on athletic programs in schools, although its provisions cover all academic and extracurricular aspects of school programs.

More recently, the significance of Title IX has been seen in sexual harassment cases. Because sexual harassment is a form of discrimination, this law has been used to protect all students from sexual harassment. In some cases, funding is available under this law for the purpose of education and prevention.

## Specific Ethical Concerns

According to Birdsall and Hubert (2000), statistics from the ACA Insurance Trust Fund and the ACA and ASCA Ethics committees indicate that confidentiality, parent or guardian rights, and record keeping are the top-ranked concerns of school counselors.

### Confidentiality:

A client's right to privacy is expressly asserted in all codes of ethics pertaining to helping professions. Section B.1 of the ACA Code of Ethics states that, "Counselors respect their client's rights to privacy and avoid illegal and unwarranted disclosure of confidential information." The ASCA guidelines state, "Each person has the right to privacy and thereby the right to expect the counselor–client relationship to comply with all laws, policies and ethical standards pertaining to confidentiality." On group work and confidentiality, the ASGW guidelines state, in section 3.b.:

> *Group counselors stress the importance of confidentiality and set a norm of confidentiality regarding all group participants' disclosures. The importance of maintaining confidentiality is emphasized before the group begins and at various times in the group. The fact that confidentiality cannot be guaranteed is also clearly stated.*

These guidelines were written with sufficient room for interpretation, and one might also imagine that there are a host of exceptions and special considerations. For instance, **there are three generally accepted conditions under which confidentiality cannot be protected:**

1. **When a counselor believes that a client is a danger to himself or herself, or to others, the counselor is obligated to report to the appropriate third party.**

There are two court cases that particularly influence this obligation. The *Tarasoff* case is certainly well known by anyone who has received professional training since the late 1970s. In this case, a psychologist

became aware of homicidal threats made against a college student and chose not to warn the potential victim. After the student was murdered, the victim's parents sued the University of California. The outcome of the case compels **all mental health professionals to breach confidentiality of clients who, "while in therapy, clearly express an intention to do serious bodily harm to a known or identifiable person"** (Fischer & Sorenson, 1996, p. 31).

The second case involves a 13-year-old student whose death was the result of a suicide pact. Friends of the victim made two counselors aware of the suicide threat. However after visiting with the student, who denied suicidal intentions, the counselors chose not to disclose information to the student's parents. The student was later killed in a suicide act with another student. This case, known as *Eisel v. Board of Education*, 1991 (Fischer & Sorenson, 1996), **resulted in a ruling that requires counselors to use reasonable care to attempt to prevent suicide when they are aware of suicidal intent. In most cases this requires the counselor to notify the parents.**

It is clear that the courts see limits to the idea of confidentiality and **extend responsibility for the prevention of harm to clients or others to mental health professionals. However, the question of how to determine when issues warrant invoking the duty to warn or protect is a perplexing one.** For example, is a counselor who becomes aware that a student is likely to be driving under the influence of alcohol obligated to report? What if a counselor is aware that a student is engaging in risky sexual practices? Unfortunately, there are no clear guidelines for making decisions in cases such as these. According to Isaacs and Stone (1999), the **degree of danger of the behavior is a factor in determining whether or not to breach confidentiality. Imminent danger, specificity, and age and maturity of the individual are also standards to apply to a potential situation.** Isaacs and Stone (1999) found that counselors in practice, "tend to see serious drug use, abortion, use of crack cocaine, suicide intent, robbery, and sex with multiple partners as areas which are serious enough to warrant a breach of confidentiality, though less so at the high school level" (p. 265). Further discussion of this topic is found in the section on minors and confidentiality in this lesson.

*2* **When a client discloses any form of physical or sexual abuse involving a child, a counselor is obligated to report.**

All states require reporting child abuse or neglect if the result is physical injury. Requirements vary across states on mandatory reporting of sexual abuse, or emotional or mental injury (Fischer & Sorenson, 1996). There is also variability concerning statutes of limitations for reporting (Baker, 2000). When a counselor in the school suspects abuse, there are a several factors that need to be considered. First, no state requires that the reporter be certain that abuse has occurred (Fischer & Sorenson, 1996). A counselor is only obligated to report if there is sufficient reason to suspect that abuse is occurring. Once abuse has been reported to a social service agency or child protective services agency, it is that agency's responsibility to confirm or disconfirm the abuse.

**Procedures for reporting abuse vary from state to state. In some instances, it is the responsibility of the individual who suspects abuse, in others a person within the school is designated as the reporter. Because there is such variability in reporting guidelines, it is essential that school counselors take time to educate themselves about state law and school policy.** It is also important to note that definitions of what constitutes abuse vary from state to state. Because all states have penalties for failure to report, it is incumbent on the counselor to know his or her state's definition of reportable abuse.

*3* **When there is a court order to disclose confidential information, a counselor must ultimately comply.**

Some states have exceptions to this condition under laws granting privileged communication. For example, Montana law protects confidential information that is disclosed during a counseling session from all legal requests. If the student is a minor, however, the privilege belongs to the parents. In any case, **both confidentiality and privileged communication belong to the client, not the counselor; therefore if the client grants permission to share information, the counselor must comply.** One must also remember that in cases regarding confidentiality and privileged commu-

nication, the courts have the ultimate power. It is possible to present reasons for not breaching confidentiality or privileged communication before a judge, yet, once the judge reaches a decision, counselors must submit or face legal consequences. Finally, privileged communication does not absolve mental health professionals of their responsibility to prevent harm to the client or others, or to report abuse. These issues transcend the privilege.

## Minors and Confidentiality:

According to Birdsall and Hubert (2000), **minors have an ethical right to expect confidentiality from their counselors and counselors are ethically responsible for asking permission before disclosing information shared in counseling.** Legally, however, there are conflicting opinions. Fischer and Sorenson (1996) **suggest that counselors do not have to disclose information from counseling sessions to the parents. Others believe that the FERPA allows parents the right to know what is happening with their children in school** (Isaacs & Stone, 1999). **It is therefore suggested that counselors speak with parents** (or parents and student if one feels that it's appropriate) **early in the counseling relationship to reach an understanding of the importance of confidentiality. If parents express a desire to know what is happening in the counseling sessions, one might consider whether or not to meet with the student beforehand.** A meeting such as this would give the counselor and student an opportunity to discuss what types of information would be shared, and hopefully preserve a trusting relationship. In most cases, general information is sufficient (i.e., "your student is making steady progress in making healthy decisions" rather than, "your student has used drugs in the past but hasn't in the last two months.")

### *Confidentiality and Student Records*

Student records can be divided into formal and informal types. Formal school records are kept in a student's cumulative record file. Although systems vary from school to school, most cumulative records include personal demographic information about the student and family, report cards, results from standardized achievement tests, interest inventories, aptitude tests, etc. It is important to note that these records follow students who transfer to other schools, and they accumulate until the student graduates or leaves school.

There are also informal records generated by teachers, administrators, and counselors that are not stored in the cumulative file. These are usually notes that deal with the day-to-day experiences with students, and are useful in promoting continuity and consistency in the student's educational experience. For example, a math teacher might keep notes regarding a student's strengths and weaknesses to help monitor the students progress. Counselors also keep notes of the work they do with students. In fact, they are **ethically obligated to keep progress notes, especially given the potential size of their caseload. Notes remind counselors of students' progress and serve as documentation of services provided as well as indicators of quality of care.**

This is another case in which the school setting complicates the understanding of how to handle an ethical situation. Client record keeping in a private practice or in a mental health center is a fairly straightforward process; however, when the client is also a student who is being seen within an educational context, one is not always sure how ethical guidelines are reconciled with school law. For this reason, **many agree that a counselor should take a very conservative approach to record keeping and operate under the assumption that any note made about a student interaction may be read** (Birdsall & Hubert, 2000). To provide the best protection possible to client information, it is suggested that school counselors follow a few guidelines:

**First, as mentioned earlier, personal notes are not subject to FERPA mandates. Technically, personal notes are those that are not seen by anyone else.** If they are shared with another colleague, or typed on a computer that is not secure, they are not considered personal.

**Second, the information contained in notes ought to be concise, objective, and as free of interpretation or personal conjecture as possible.** Notes should contain date of contact, name of student, objective observations, any reminders for future sessions, and any contacts made as a result of the session. **It is extremely important that notes not contain any diagnostic impressions or test interpretations that the professional is not qualified to make.**

**Finally, notes should be written as soon as possible after the contact.** This will insure that the facts are accurate and uncontaminated by interactions with other students. When formatting notes, leave no room or empty space between entries; this is to avoid the appearance of altering or adding information after the fact.

### *Informing People in a Need-to-Know Position*

It is inevitable that a counselor will have information about students that either directly or indirectly involves others in the school building. Isaacs & Stone (1999) note that **minimal disclosure to teachers or administrators is sometimes appropriate because they are often in a position to positively impact a student.** For example, consider the case of a sixth-grade female student who is just beginning to show some behaviors associated with eating disorders. She is voluntarily seeing a counselor in a school-based mental health clinic, and her parents are aware of the problem, but they don't really want others to know. The counselor knows that the girl has been excusing herself from class after lunch to purge herself, and so far the teacher is unaware of her behavior. Should the counselor inform the teacher? Should the administrator know about this? If so, should the student be made aware of the disclosure?

In some instances, a counselor may make a decision to disclose confidential information to others who are in a "need-to-know" position. In the case described above, it is possible that the teacher might approach the counselor for advice on how to handle the student who is always claiming to be ill after lunch. The counselor needs to make a decision whether or not it is in the best interest of the student for his/her teacher to know. If the teacher can provide assistance in the student's treatment, or if it is possible that the teacher might innocently exacerbate the student's condition because they didn't know, the counselor may decide to disclose pertinent information. Similarly, if the student's condition has progressed to a point where her health is seriously endangered, it may be necessary, as a matter of school policy to inform the administrator of the student's condition. In fact, **most school administrators need to be informed any time there is a case that has potential legal implications for the school. If conditions exist that suggest the school would be held liable for the student's condition, the counselor should make every effort to inform an administrator in order to insure that school policy is being followed (and thus attain the legal protection offered through the school system).**

In any case, the ethical guidelines clearly indicate that a counselor do everything possible to safeguard confidentiality. **If there is a case in which it appears necessary for others to be aware of confidential information, it is always beneficial to talk with the student first and work on preserving trust. Additionally, the counselor should attempt to clarify the student's expectations and discuss how the counseling relationship can continue after disclosure** (Baker, 2000; Muro & Kottman, 1995; Schulte & Cochrane, 1995). **As always, the potential damage to the counseling relationship has to be weighed against possible good from the action.** While there are times when it is beneficial to not be completely forthcoming with a student, (e.g., if the knowledge increases risk or danger for the student), generally speaking, honesty and straightforwardness are usually best.

### *Informed Consent*

The school context is really no different than any other with regard to the importance of informed consent. Whenever a counseling relationship begins, **it is incumbent on the counselor to let the client, as well as their parents if the client is a minor, know what is involved in the counseling process. Generally, this covers the limits to confidentiality and privileged communication, as well as any possibilities for consultation or supervision that might be involved.** This information should be given in a developmentally appropriate way.

It has not always been the practice of school counselors to present informed consent in writing; **however, according to Birdsall and Hubert (2000), there are legal and relational consequences:**

> *To the extent that school counselors do not provide written information about expectations and conditions within the counseling relationship they are promoting a form of paternalism that communicates, 'Trust me, I will take care of you.' There isn't much room for healthy client growth in such a relationship. (p. 30)*

Depending on the situation, however, it is not always possible to provide written information during the initial contact. For example, a student may approach a counselor in the hallway or in the lunchroom with a problem. In these cases, it is still important to inform the student verbally of limitations to confidentiality, and then later, in the office, review the informed consent form with the student.

### *Parental Permission*

In most cases, it is desirable to have the parents' permission for their child to participate in individual or group counseling. Many parents are concerned about their children and want to know about their time in school. At the same time, parents' support and cooperation can be a valuable part of the counseling process; indeed, parents are often part of the solution to their children's problems (Birdsall & Hubert, 2000; Welfel, 1998).

Whether or not parental permission is required for a child to be seen by a counselor depends on several factors. **If the child is unable to form an informed consent, in most cases the responsibility falls to parents.** However, the **courts have granted exceptions to requiring parental consent under the following conditions. The first involves a "mature minor"—a minor who has the cognitive and emotional capacity to understand the counseling process.** According to Fischer and Sorenson (1996), the status of "mature minor" is determined by the courts and/or state law, and often varies from state to state. Counselors are encouraged to consult with state laws concerning treatment of teenagers. **The second is for emancipated minors who are legally independent from guardians or parents; and the third is in the case of an emergency (e.g., in the case where the immediate health or well-being of a student is threatened).** In all three cases, a minor can be seen legally without parental permission. This is most certainly the case when a minor is being seen in a private setting; however, additional consideration in light of FERPA must be made if counseling occurs in schools. Baker (2000) reports:

> *Part II of FERPA states that parental consent for minors must be obtained if the student undergoes medical, psychological or psychiatric examination, or treatment, or participates in any school program designed to affect or change the personal behavior or values of a student. (p. 77).*

**Many schools interpret this to include counseling services, and thus require parental permission for any minor, regardless of whether or not the situation falls under the three cases stated above.** Because counselors often see students on a drop-in basis or in crisis situations, it is not always possible to obtain parental permission before seeing the student. It is generally accepted that a counselor can see a student one or two times before obtaining parental consent to continue.

## HIV/AIDS:

Section 504 of the ADA is particularly significant to schools who have constructed policies on the education of students with HIV/AIDS. Section 504 generally protects an HIV-infected student's right to be in school, although it is left up to individual schools to determine policy regarding precautionary procedures and confidentiality (Cobia, Carney, & Waggoner, 1998). Section B.1.d. of the ACA code of ethics states:

> *A counselor who receives information confirming that a client has a disease commonly known to be both communicable and fatal is justified in disclosing information to an identifiable third party who by his or her relationship with the client is at high risk of contracting the disease.*

Clearly the key phrase, "identifiable third party at risk," does not apply to classmates or teachers who are not engaging in behaviors known to spread the disease. It is important to note, however, that Section 504 gives schools discretion in determining policy. In some schools, disclosure to teachers, janitors, and administrators is required. A counselor working in such a school would be obligated to follow school policy, or risk dismissal.

## Counseling with Diverse Groups:

Recent advances in our understanding of multicultural issues and diversity have led to greater awareness of a counselor's ethical responsibility to minority clients.

Many agree that counseling and psychotherapy are based in Western ideology, and therefore don't always serve the best interests of ethnic minorities. The ACA code of ethics and the ASCA code both include statements on the importance of understanding cultural backgrounds and the obligation to prevent discrimination. Thus, a counselor working with a client from a different cultural background is ethically obligated to understand and work within a student's worldview and value system. This requires that counselors be aware of their own values and take care not to impose them on clients. Furthermore, it is important to provide alternative choices for therapy where called for, including traditional healing, cleansing ceremonies, etc. Finally, it may be necessary to act as an advocate when systemic forces undermine the individual autonomy of a minority client.

## Group Counseling in Schools:

Counselors who work with groups in schools need to be aware of several factors. It is extremely important to read and understand the ethical concepts that relate to group counseling, as they sometimes differ significantly from concepts that apply to other types of counseling settings. First, **parental permission is most likely required under the FERPA guidelines, as groups could be construed to constitute an activity designed to change a student's behavior or values.** Therefore, it is important to communicate the purpose of the group, intended goals and outcomes, the counselor's qualifications, and the planned length of group counseling very clearly to parents. It would also be important as a matter of informed consent to provide parents with some information about the group process and any limitations to confidentiality.

With regard to confidentiality, the ASGW code states, **"The importance of maintaining confidentiality is emphasized before the group begins and at various times in the group. The fact that confidentiality cannot be guaranteed is also clearly stated."** Given the difficulty involved in maintaining confidentiality for groups in schools, Muro and Kottman (1995) suggest that counselors devote a great deal of time to the importance of confidentiality in pregroup screening sessions, as well as during the first few sessions.

## Abortion:

The relevant professional literature is complicated by the amount of legal activity surrounding this issue. A number of states have passed laws requiring parental consent for abortion and challenges to each case are pending in many areas. **The counselor should consult with colleagues as well as a lawyer to ascertain the current state of this issue. In most cases, courts have ruled that the decision to have an abortion should be left to the young woman and her physician** (Fischer & Sorenson, 1996).

A further dimension to this issue involves school policy. According to Fischer and Sorenson (1996), school boards have the right to create policy about abortion counseling, (i.e., whether or not a counselor should engage in counseling a student who is considering abortion, or whether or not disclosure to parents is required) as long as they are consistent with state and federal law. In most cases, a counselor who provides competent service to a student will not be held liable in a legal case involving abortion, even where school policy prohibits such interaction. However, a counselor in such a situation could be terminated for violating school policy if that policy required disclosure to parents, or if it prohibited the counselor from engaging in counseling where abortion was presented as an alternative to pregnancy.

## Ethical Decision-Making Model:

Birdsall and Hubert (2000, p. 30) assert that ethical dilemmas have the following characteristics:

- **There are reasonable choices between two or more courses of action**
- **Each choice presents significant potential consequences**
- **Each course of action can be supported by ethical principles**
- **The selection of either course will compromise an ethical principle**

Certainly there are many instances in a school setting where federal, state, and/or institutional values clash

with the values of the counseling profession, thus creating true ethical dilemmas. Sometimes available guidelines are clear as to the appropriate course of action; however, often a course of action will compromise the professional values of the counselor or the rights of a student/client. In such cases, it is important for the counselor to have a systematic model for effective decision making. There are several models available in the literature, most closely resemble problem-solving models that are familiar to counselors. **What follows is a summary of the model provided in a free publication of the ACA entitled, "A Practitioner's Guide to Ethical Decision Making"** (Forester-Miller & Davis, 1996).

*1* **Identify the problem—Gather as much information as possible about the situation, including whether or not it involves legal, ethical, institutional, or clinical issues.**

*2* **Consult appropriate ethical codes—In a school setting, the codes of the ACA, ASCA, and ASGW (if a group is involved) are especially helpful.**

*3* **Clarify the nature and dimensions of the ethical dilemma. The following procedures can be employed to help work through this step:**

A. Consider the moral principles of beneficence, nonmaleficence, justice, and fidelity. How are possible courses of action influenced by these concepts?

B. Review current literature related to the situation.

C. Consult with colleagues and/or supervisors.

D. Consult with professional organizations. Most have ethics committees and are more than willing to assist in the ethical decision-making process.

*4* **Generate potential courses of action. Again, consultation with an experienced professional colleague or supervisor is suggested.**

*5* **Identify and consider all consequences of possible courses of action.**

6 **Evaluate the potential course of action. Does it present further ethical dilemmas?**

*7* **Implement the course of action**

## Conclusion

In most cases, ethical issues in a school are an intersection of competing values and thus require careful deliberation of ethical principles, contextual factors, and institutional demands. This can be a daunting task, especially for a school counselor who, by virtue of his or her position, may feel isolated from the greater school community. Because of this, it is extremely important for a counselor to have a seasoned and experienced colleague to consult with when facing difficult ethical decisions. Being able to consult with a colleague not only relieves the sense of isolation, it provides perspective and objectivity that might be missing otherwise. By doing so, one can be as certain as possible that all factors have been considered carefully and that the professional standard of care has been met to the greatest extent possible.

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## Questions Based On This Lesson

*To earn CE credits, answer the following questions on your quiz response form.*

**5. Which one of the following statements is *not* true of ethical codes?**

A. Ethical codes are dynamic and evolve with time.

B. Ethical codes are legal documents, and as such carry legal consequences for failure to uphold them.

C. Most ethical codes are built upon the moral principle of beneficence, nonmaleficence, justice, fidelity, and human autonomy.

D. Most ethical codes require interpretation on the part of the practitioner.

**6. Under the Federal Educational Rights and Privacy Act of 1974 (FERPA), personal, private notes:**

A. Are part of the student's educational record, and therefore available to the student or parent upon their request.

B. Are regarded as inflammatory and libelous material, and are therefore discouraged.

C. Belong to the counselor, and are considered confidential as long as no one else has seen them.

D. Must be stored on school property and made available to others on a "need-to-know" basis.

**7. Regarding confidentiality, which one of the following is *not* true?**

A. When a counselor believes that a client is a danger to himself or herself, or to others, the counselor is obligated to report to the appropriate third party.

B. When there is a court order to disclose confidential information, counselors must ultimately comply.

C. Counselors are obligated to report any form of physical or sexual abuse involving a child.

D. If a client grants permission to share privileged or confidential information upon legal request, the counselor can determine whether or not he should disclose it.

**8. Which one of the following examples of federal legislation is most useful in determining the educational rights of a student with HIV/AIDS?**

A. Section 504 of the Americans with Disabilities Act.

B. FERPA

C. IDEA

D. Title IX.

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# Managed Care as an Ethical Issue

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## Introduction

This lesson will provide a basic introduction to managed care, with an emphasis on ethical issues created by the managed care environment for mental health providers. Such issues include limitations on basic services, decisions about disclosure of managed care's effects on treatment, the adoption of brief therapy as an industry standard, and new problems with confidentiality, informed consent, diagnosis, and assessment. In addition to knowledge about these issues, readers will learn about potential resolutions relevant for individual practitioners and broader steps that could benefit the mental health field.

Psychotherapists in today's healthcare system find themselves caught in the horns of a very difficult dilemma. On one hand, most clinicians would like to provide the best services possible to their clients. On the other, most managed care companies would like to provide the most efficient, least costly services. While these two approaches may not appear to differ greatly, in practice they can be worlds apart. A brief elaboration will help to illustrate the potential gulf between these two positions. When therapists traditionally considered best practices, they thought in terms of a beginning, middle, and end of therapy (Meier & Davis, 2000). Beginning sessions were devoted to creating a working alliance between therapist and client and gathering sufficient information to plan an intervention. Middle sessions were devoted to implementing that intervention, be it a set of graduated behavioral tasks or the working through of the therapeutic relationship. Finally, several sessions were set aside to terminate counseling; these session were useful for summarizing the progress made and setting the stage for coping with future events. Whatever the theoretical stance, sufficient sessions were available to individualize this sequence and provide maximum benefits for each particular client.

In today's managed care environment, a new set of principles applies whether the therapy is actively managed by a third party or a managed care philosophy is employed in a setting such as a university counseling center (Williams & Edwardson, 2000). Managed care principles center around cost containment (Cooper & Gottlieb, 2000; Karon, 1995; Miller, 1995; Nevin, 2000; Pingitore, 1999). **Managed care organizations (MCOs) use a host of proce-**

**dures to drive costs down, including, but not limited to session limits, preauthorization review, utilization review, and delay of payment for services already rendered. Even the managed care companies with the best intentions find themselves in a predicament: essentially, they earn revenue not by managing the quality of care, but by limiting the costs of health care.** As Modell (1999) noted, "While managed care companies profess to being committed to caring for their enrollees, they profit primarily by doing as little as possible" (p. viii). **There may be significant differences across companies (and even over time for the same companies) in the extent to which they constrain care, but the bottom line with for-profit MCOs and their mental health carve-outs (i.e., companies that manage only mental health services) remains the bottom line.**

For experienced mental health clinicians, managed care's introduction, growth, and current dominance is an astounding turn of events. Welfel (1998) summarized the prevailing outlook by stating that "the limits set on the kinds or duration of care that can be reimbursed have prompted many mental health professionals to view access to quality care, particularly under managed care, as a sham" (p. 320).

### Background:

Before describing the ethical problems resulting from managed care, a brief review of its development is in order. Managed care refers to the oversight of medical or mental health care delivery by a third-party whose purpose is to limit care only to that deemed medically necessary (Davis & Meier, 2000). **The major reason usually cited for the ascendance of managed care is the spiraling costs historically associated with all forms of health care** (Davis & Meier, 2000); for example, Mordock (1996) **estimated that health care costs over the past two decades were rising at double the rate of inflation.** To control costs, the federal government and business groups have backed legislation and regulatory decisions for the past three decades (e.g., ERISA, Diagnostic-Related Groups, the HMO Act of 1973) that were designed to foster the growth of managed care. These actions succeeded: **by 1997, 85% of employees in employment-based health plans belonged to managed care insurance plans** (Pedulla & Rocke, 1999), **and the early to mid-1990s saw the end of double-digit annual increases in the costs of health care.**

A host of other problems, however, were created by managed care (see Davis & Meier, 2000). The central issue is that managed care companies have few or no legal, regulatory, or ethical principles to balance their cost-containment focus. For example, the Employee Retirement Income Securities Act (ERISA) of 1974 is federal legislation designed to protect workers' retirement plans (Pedulla & Rocke, 1999). **In health care, the primary effect of ERISA has been to prevent people who have been denied treatment by their MCO from suing their insurer for inappropriate decisions** (Davis & Meier, 2000). **ERISA also prevents clients from suing for damages for injuries, pursuing external appeals of benefit denials, and obtaining urgent care decisions.** Because the law was designed to "free employers subject to ERISA from having to meet a patchwork quilt of differing state laws" (Pedulla & Rocke, 1999, p. 2), ERISA superceded all state laws regarding employee benefit plans. Pedulla and Rocke (1999) concluded that **ERISA has blocked patients injured by managed care from holding these organizations accountable for their health care decisions.**

## Ethical Issues Associated With Managed Care

All helping professionals have principles holding them to high standards for the provision of care to their clients (e.g., American Psychological Association, 1992; American Rehabilitation Counseling Association, 1987; American School Counselor Association, 1992). When the provision of care depends on factors other than opportunity or need, the resulting ethical conflicts are fundamental and pervasive (Galambos, 1999). Four such conflicts are described below.

### Limits on the Provision of Basic Services:

Counselors who work with MCOs may have implied or explicit obligations to place the financial well-being of the MCO over the needs of the individual client (cf. Galambos, 1999). MCOs quickly discovered that the fewer services they reimburse, the greater the profit. Thus, **managed care companies avoid paying for ser-**

**vices through a wide variety of mechanisms, including denying treatment, prematurely terminating counseling, and authorizing counseling through utilization review but then failing to pay for the services provided.** ***Capitation*** *refers to payment systems for which reimbursement is limited to a fixed amount per person in the insured population.* In other words, MCOs may offer health care providers a flat fee for treatment, regardless of the number of sessions. In such situations the counselor now has a dual role: provide the best possible care to the client and provide the least expensive (i.e., least time-consuming) care. **Capitation may force clinicians to decide, regardless of need, which clients receive fewer sessions.**

Many MCOs preauthorize sessions in small blocks and require utilization review after those sessions are used. The rationale is that more sessions will be granted if the client continues to have a medically necessary diagnosis and makes progress in therapy. In practice, however, the MCO typically authorizes a total number of sessions far fewer than many therapists find useful. Treatment goals are difficult to set because the length of treatment is uncertain. **When the therapist and client do not know when therapy will end, but are aware that the end may be premature, the therapy may change significantly** (Davis & Meier, 2000). Both therapist and client, for example, may have difficulty developing a working alliance.

**A clinician may also have to decide whether to push for additional sessions for a client when it may jeopardize the clinician's standing with the MCO** (Bell, 1999). Some MCOs provide clinicians with a report card describing their average number of sessions per client during a certain time frame. The implicit (and sometimes explicit) message is that the clinician should not exceed the company's criteria (e.g., the average found in the MCO's clinical sample). Managed care can also result in increased liability for clinicians because **clinicians may have an ethical and legal obligation to appeal treatment denials** (Sauber, 1997). For example, the court case of Wickline v. State of California (1986) decided that it is the provider's responsibility to exhort insurance companies for adequate care (Newman & Bricklin, 1994).

## Role Induction and Disclosure of Treatment Information:

Most ethical principles advocate for full disclosure of important information that may affect treatment. These can include cost constraint issues with the MCO, although **ethical guidelines typically do not specify exactly what to disclose.**

The content and extent of disclosure around MCO cost constraint problems require careful consideration. Although a provider's first response may be to share all of the problems associated with a particular MCO with a new patient, caution is in order. Pomerantz (2000) asked 358 undergraduate students to indicate their attitudes toward psychotherapy before and after they received information about a typical psychologist's beliefs about managed care. Pomerantz found that after the students viewed the psychologist's beliefs (based on an actual survey), they were significantly more likely to believe that managed care would have a negative impact on treatment. They were also less likely to see an independent practitioner, use insurance benefits to pay for psychotherapy, and trust that the therapist would work toward their best interests. Pomerantz concluded:

> *Even among those initially amenable to psychotherapy, the knowledge that their prospective psychologist perceives managed care as a source of unwelcome professional and ethical concerns that negatively impact treatment causes prospective clients to be significantly less likely to pursue treatment or use health insurance benefits to pay for services (p. 165).*

Although the generalizability of this study's sample to the population of individuals seeking psychotherapy is questionable, these results suggest that clinicians should carefully consider the type of information they share with individual clients about managed care. For example, it may be advisable to indicate that although an insurer advertises the availability of 20 sessions of mental health care per year, in actual practice only 6 sessions are typically authorized (cf. Davis & Meier, 2000). On the other hand, **a clinician's frustration with that insurer's past delay of payment for pro-**

**vided services is not information that needs to be shared with clients.**

**The major topics of information to consider sharing with patients relate to treatment cost, treatment length, and confidentiality.** Cost can be straightforward: for example, the MCO may reimburse 50% of the fee. Treatment length and confidentiality (both described in more detail below), however, may be more problematic. A MCO may advertise that it offers 20 sessions per year, but in practice may only authorize 6 sessions annually for each of its clients, using lack of medical necessity as the pretext for denying further sessions.

## Brief Therapy:

Most clients will receive some form of brief therapy (BT) in a managed care environment. Budman (1981) describes **BT approaches as "those that emphasize the efficient, effective use of time, while considering the relative cost, outcome, and benefits of services offered"** (p. 463, italics removed). BT can be difficult to describe since (1) proponents of different approaches argue that BT may be comprised of one session or may require weekly sessions for several years, and (2) BT often appears to be simply a shortened version of other counseling approaches (Meier & Davis, 2000). What does seem to be continuous in BTs different forms is that **BT counselors are more active and directive than those who use traditional approaches. Symptom reduction and restoration of functioning are primary goals, and clients presenting with clearly defined complaints are most appropriate for BT.**

Although therapy traditionally has taken place once a week, managed care has changed the frequency of sessions. Some managed care companies actively discourage weekly sessions in favor of bimonthly or monthly visits. A model of BT developed by Cummings and Sayama (1995), for example, specifies that clients return to therapy periodically for short-term interventions when crises occur or symptoms become distressing. The Cummings and Sayama model clearly dovetails with the practical realities (i.e., utilization and reimbursement rates) of current managed care companies.

Whether BT represents a high standard of care depends upon the individual client, group, couple, or family. Research results have been ambiguous; some studies show better outcome with more sessions, while others find no difference in outcome (Barber, 1994; Consumer Reports, 1995; Meyer et al., 1998; Steenbarger, 1994). Limiting the number of sessions, however, profoundly affects the way therapy is practiced. For example, clinicians must carefully consider how much time they have to (a) gather information, assess the client, and develop a working alliance; (b) implement any intervention; and (c) spend on termination. Termination becomes increasingly complex when its occurrence is unpredictable and neither the clinician nor the client know when or if the MCO will continue to authorize treatment.

## Confidentiality and Informed Consent:

The boundaries of confidentiality have clearly expanded under managed care. More individuals see information that was previously kept between therapist and client, and greater amounts of information are shared than in the traditional fee-for-service system. Utilization reviews, where the clinician provides information about the client and therapy progress, may be sent through the mail, fax, or e-mail and thus may be lost in transit or at the company. In contrast to past methods, **many insurers now require clients to sign a blanket release of information form, and it is often unclear who in the MCO sees clinical records** (cf. Davis & Meier, 2000). Because the release may have been buried in several pages of information and agreements, clients may not remember that they have signed such a release.

## Diagnosis and Assessment in the MCO Setting:

Ideally, MCOs would like to introduce more efficiency into the healthcare system by creating a feedback loop of the following sort:

**Clinical Service ⟶ Effectiveness Data ⟶ Reduce Costs and Improve Service**

Thus, outcome data would be collected as part of service delivery. **Analysis of those data could help provide answers to such questions as treatment effectiveness, as well as the relation of effectiveness and variables such as treatment length and treatment type. However, serious obstacles exist in obtaining valid outcome data.** For example, the

Global Assessment of Functioning (GAF; American Psychiatric Association, 1994) scale, perhaps the most widely used outcome measure, is a 100-point scale that allows clinicians to summarize a client's overall functioning and symptomatology with a single rating. Clinicians typically make GAF ratings at intake and termination. The basic issue with the GAF is its transparency: Clinical raters can manipulate the score, making the client appear as distressed or functional as necessary to obtain additional sessions (cf. Speer & Newman, 1996).

Therapists who know that particular MCOs are likely to deny needed treatment may be tempted to "upcode" or exaggerate GAF scores or diagnosis severity (Cooper & Gottlieb, 2000), which causes a number of problems. First, the practice is usually considered unethical. In the early 1990s, for example, upcoding problems represented a significant portion of the ethical complaints filed against psychologists (Wolfel, 1998). Also, the therapist is violating the terms of the contract signed with the company and perhaps committing insurance fraud.

Although the purpose of utilization review is to decide on services for a particular client, managed care companies may follow relatively simple rules. For example, Davis and Meier (2000) reported that utilization reviewers for a particular MCO, no matter how distressed the client, simply concluded the 15-20 minute review with the clinician by granting four sessions (but no more), with the caveat that another review would be needed if additional sessions were required. Other companies may base the number of allowed sessions on a DSM diagnosis or GAF score. One MCO did vary the number of sessions granted based on DSM-IV Axis I diagnosis (American Psychiatric Association, 1994), even though the severity of the symptoms or situation varied from client to client and despite the requirement that an extensive form be completed for each review (Davis & Meier, 2000).

## Potential Resolutions

How can clinicians begin to resolve these sorts of ethical problems? While some resolutions will be specific to particular MCOs, several general guidelines can be offered.

**Provision of Services and Treatment Length:** **In regard to the provision of services and treatment length, clinicians cannot abandon their clients, but must act as the client's agent** (Glosoff, Garcia, Herlihy, & Remley, 1999; Lazarus & Sharfstein, 2000). This may seem like simplistic advice, but this principle may be costly, both in terms of money and time. Continuing to provide services at reduced fees or pro bono means a drop in income for agencies and individual practitioners, and may even translate into a degree of financial risk (cf. Buckloh, 1999). In general, clinicians should strive to place their clients' needs over their own financial interests. As Morgan and Ruffins (1999) state, "it is this matter of allowance, of who pays the money, of how much and to whom, that may ultimately be where psychotherapy is most vulnerable to corruption" (p. 253).

If a client's progress is not sufficient in the number of sessions authorized by the MCO—essentially, by some version of Brief Therapy—Davis and Meier (2000) recommend that the clinician consider the following options:

1. **Limit the goals to the most distressing current symptoms and postpone attention to contributing or less distressing issues. The Cummings and Sayama (1995) model described previously, where client returns intermittently to address acute symptoms, fits this approach. Complications can arise, however, as when the presenting problem turns out not to be the primary focus of therapy (Acuff et al., 1999). The other options can then be helpful.**
2. **Share the session issue with the client, as soon as appropriate, so that both individuals can help decide how far to proceed. Consider whether it makes sense with any particular client to present a positive and hopeful approach to the time allowed. While the allotted sessions may be insufficient for problem resolution, the therapist might reasonably expect that the client will obtain significant relief if both client and therapist focus and work together.**

3 **Help the client decide whether he or she will pay for therapy when insurance payments are exhausted. Once therapists develop experience with particular managed care companies, they can gauge the number of sessions a particular client is likely to receive. Sharing that number with the client, along with an estimate of how much progress is possible within that number of sessions, establishes a basis for discussion of the possible costs as well as how much the client values resolution of the problem.**

4 **Refer the client to a counseling agency with the ability to continue therapy post insurance. Even if the client could afford several sessions with you, you should refer the client to another clinician or agency as soon as it is decided that a referral will be made. Exhausting clients' insurance benefits and then sending them elsewhere is both unethical and countertherapeutic. In addition, some agencies cannot afford continued therapy once the MCO has refused further reimbursement.**

5 **Continue working with the client pro bono or at a significantly reduced fee. This, of course, depends upon the financial status of the individual practitioner, agency, clinic, or hospital where services are provided.**

### Confidentiality and Informed Consent:

Many authors recommend that **clients be kept informed of the specific information that will be shared with an MCO** (e.g., Lazarus & Sharstein, 2000). Similarly, **informed consent may need to be continuous throughout therapy**, rather than simply discussing any treatment issues at the beginning of therapy (American Psychiatric Association, 1987; Cooper & Gottlieb, 2000). Clients may also to choose to refuse disclosure, but they run the risk that the MCO will not cover the therapy. Finally, some clinicians show clients a copy of the form the MCO requires the therapist to complete to request therapy sessions.

### Diagnosis and Assessment:

Clinicians may have the least flexibility with diagnosis and outcome assessment. In the medical model mandated by managed care, diagnosis cannot be avoided. Typically, MCOs that employ outcome assessments require them for continued treatment (even though neither clinician nor client receive compensation for the time involved). Because standards for data collection and outcome assessment remain in their infancy (cf. Meier & Letsch, 2000), **clinicians with knowledge of psychometric principles may be able to request information about the validity of the assessments used by particular MCOs and challenge their usefulness**. Such requests are likely to be ignored or dismissed if the real purpose of the assessment is to contain costs (Meier & Letsch, 2000). No current measures have sufficient validity for sole use as the primary method of denying or continuing treatment; that is, a decision to terminate treatment should not be made only on the basis of a test score, without clinician and client input. **It may also be useful to explain to clients, if appropriate, that MCO assessments are used for the purposes of utilization review by the company and have limited or no impact on the clinician's treatment decisions.**

## Broader Solutions

Managed care was essentially a business-oriented political solution to the health care crisis. What is now required is what Sabin (1999) called ethical managed care, that is, "providing the best possible care to individuals while optimizing use of the resources available for the total population" (p. 64). As Cooper and Gottlieb (2000, p. 231) maintained, "No one has found the perfect system for allocating health care. What we do know is that leaving it solely to market forces results in serious ethical challenges and the system must be revised." MCOs will continue to generate unique and frequent problems for clinicians; therefore, several additional steps may be worth pursuing to confront ethical issues of managed care.

### Political Activism:

Political action typically does not come easily to many mental health professionals. Faced with feelings of

hopelessness and helplessness, clinicians may refocus their energies on their clients. They avoid "the bureaucracy of the hospital or clinic or insurer . . . and do not get involved in making policy changes that might alleviate the pressures they experience" (Bell, 1999, p. 65). The shape of our health care delivery system, however, will be significantly determined in the next 5–10 years by the political process, particularly at the state level. **The choice of George W. Bush as President in 2000 likely means little change in the healthcare system through 2004, with any substantive changes at the state level** (cf. Goldberg, 2000). **Bush has already promised to veto any federal legislation that includes a declaration of the patient's right to sue MCOs for their treatment decisions.** The interests of all helping professionals and our clients will be better served if political action returns quality of care to the level of concern now accorded to cost containment.

A simple way to become involved politically is to join one or more professional organizations. Groups such as the American Psychological Association have been active in political and legislative activity related to managed care. Clinicians can also consider joining local, state, and national groups working on managed care issues (see the Appendix for a brief list), write and meet with local and state representatives, and learn about and participate in educational events such as the annual, national ***Rescue Health Care Day***. **To the extent allowed by contracts with the MCOs, clinicians can disseminate information regarding the MCO's policies to clients, the media, and other influential parties** (Acuff et al., 1999). Such direct actions require more effort, but professional advocacy is a worthy goal for all helping professionals.

### Staying Informed:

Another course of action related to political advocacy is staying informed about managed care. The mass media can be sporadic in its coverage about managed care, focusing mainly on controversial issues. Professional journals such as the *American Psychologist*, *Journal of the American Medical Association*, and *Administration and Policy in Mental Health* provide more in-depth information (Corcoran & Vandiver, 1996, p. 238, offer a more complete listing of relevant journals). Given that research suggests that some clinicians lack basic knowledge about, and skills related to managed care (e.g., Shueman & Shore, 1997), **reading a book on managed care may be an important step to learning more about managed care's procedures and effects.** Chamberlin (2000) lists Davis and Meier (2000), Glueckauf, Frank, and Bond (1996), Lowman and Resnick (1994), and Zieman (1998) as useful resources. Computer-savvy clinicians may use the Internet to stay up-to-date on managed care by searching professional organizations' websites (e.g., www.patientadvocacy.org, www.naswdc.org, www.nbcc.org). The first author of this lesson (S.M.) also maintains a website that includes managed care links (www.acsu.buffalo.edu/~stmeier). Using a web search engine with "managed care" as a search term will produce a large number of relevant resources.

#### *Adaptation*

Finally, the theme of much writing about MCOs in the early and mid-1990s centered on adaptation strategies. The basic argument was that adoption of managed care practices and values were necessary for clinicians' survival and adapting to this system was necessary (cf. Weisgerber, 1999). Though not a universal solution, adaptation is one method of meeting this ethical crisis. Since practitioners and agencies must often deal with a myriad of companies, it may be possible to identify the most ethically-challenged companies and consider withdrawing from their panel. In agencies where funding from government sources has been cut and where managed care represents an important source of money, withdrawal from MCOs is not a realistic option. In many other situations, however, clinicians can reduce or eliminate their relations with managed care companies, although not without some negative consequences. Such clinicians may receive fewer referrals, be labeled "inefficient," or be providing services mainly to an affluent subset of clinical patients (Weisgerber, 1999). Yet, **increasing numbers of clinicians have chosen to leave the panels of the worst companies, and some have left managed care entirely** (Glosoff et al., 1999).

## Conclusion

A reasonable conclusion from the problems described above is that it may not be possible to practice ethically

in current managed care systems. Clinicians now find themselves in systems that continually place them in unworkable dilemmas (cf. Acuff et al., 1999). Clinicians should recognize the conflicts between care and costs, adapt to and work around managed care where necessary, and act to change managed care so that quality of care begins to balance the cost emphasis. Clinicians would be wise to review their relevant ethical principles and develop new applications of those principles for their managed care environments. The alternative is to simply react to the continuous stream of methods that MCOs devise to constrain costs and services.

## Appendix

### ORGANIZATIONS WORKING ON MANAGED CARE ISSUES

| Organization | Web address |
|---|---|
| National Partnership for Women and Families | www.nationalpartnership.org |
| National Institute of Mental Health | www.nimh.nih.gov |
| Agency for Healthcare Research and Quality | www.ahcpr.gov |
| Coalition for Patient Rights | www.nationalcpr.org |
| Center for Patient Advocacy | www.patientadvocacy.org |
| National Coalition of Mental Health Professionals and Consumers | www.NoManagedCare.org |
| Center for Mental Health Services | www.mentalhealth.org |
| Families USA | www.familiesusa.org |

Note: These and other managed care related websites can be accessed through the first author's homepage, www.acsu.buffalo.edu/~stmeier.

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## Questions Based On This Lesson

*To earn CE credits, answer the following questions on your quiz response form.*

**9. According to the lesson, managed care companies constrain costs by doing which of the following?**

A. Denying treatment

B. Prematurely terminating counseling

C. Failing to provide for services previously authorized by the insurer

D. All of the above

**10. The major problem with ERISA is that it:**

A. Prevents persons who have been denied treatment from suing their insurer.

B. Resulted in significant increases in healthcare costs over the past two decades.

C. Forces states to enact local legislation to regulate health care plans.

D. Has resulted in an overwhelming number of appeals of benefit denials.

**11. Symptom reduction and restoration of functioning are the primary goals of which of these therapies?**

A. Psychodynamic therapy

B. Cognitive-behavioral therapy

C. Rogerian therapy

D. Brief therapy

**12. A carve-out refers to:**

A. An insurance companies' percentage of healthcare profits.

B. Utilization reviewers who must deny a certain percentage of cases they process.

C. Managed care companies that manage only the mental health services provided to insurance enrollees.

D. None of the above

**You have just completed this course. Please record your answers on the enclosed quiz response form. Be sure to keep a copy for your records.**

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